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END OF PROJECT REPORT

for

CHILD SURVIVAL VI PROJECT

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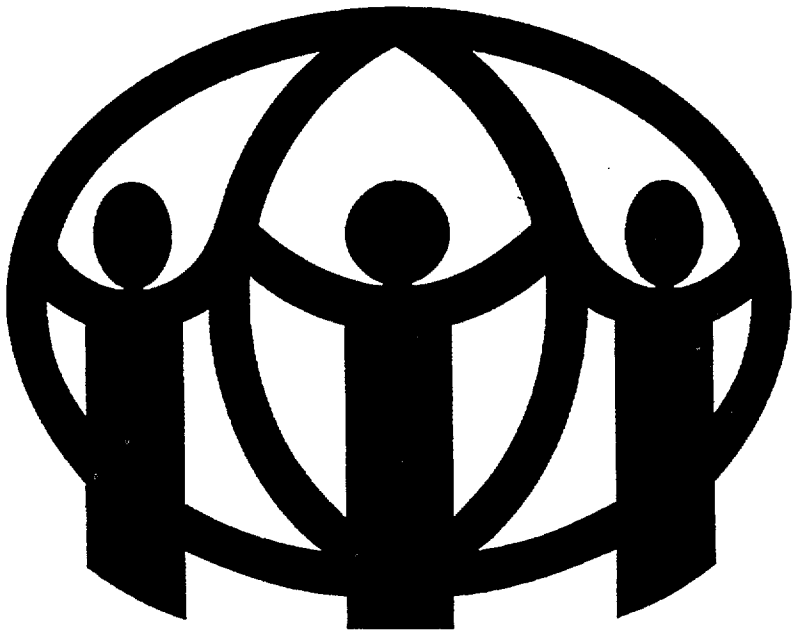
MALAWI



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FINAL EVALUATION

ADRA/MALAWI CHILD SURVIVAL PROJECT

Betsy Stephens, ISTI Team Leader
August 16, 1993

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APPENDIX

Glossary

ADD	Agriculture Development Division
ADRA	Adventist Development and Relief Agency
AIDS	acquired immune deficiency syndrome
BCG	Tuberculosis vaccine
CBD	Community based distribution
CDD	Control of diarrheal disease
CS	Child Survival
CSAC	Child Survival Advisory Committee
DIP	Detailed Implementation plan
DPT	diphtheria, pertussis, typhoid vaccine
DRCU	draught relief coordinating unit
EPI	Expanded Program of Immunization
FP	family planning
HI	health inspector
HH	household
HSA	health surveillance assistants
IEF	International Eye Foundation
MOH	Ministry of Health
MSF	Medicines sans Frontiers
NGO	non-governmental organization
ORS	oral rehydration salts
ORT	oral rehydration therapy
PHAM	Private Hospital Association of Malawi
RHO	regional health office
SEAU	Southeast Africa Union of Seventh-day Adventists
SDA	Seventh-day Adventist
TA	technical assistance
TALRES	Trans-Africa Leprosy Organization
TOT	training of trainers
USAID	U.S. Agency for International Development
VHC	village health committee
VHV	village health volunteers
WHO	World Health Organization

1. INTRODUCTION AND BACKGROUND

1.1. The Grant

1.1.1. Background

ADRA is a non-governmental organization (NGO) associated with the Seventh-day Adventist Church (SDA) and based in the U.S.A.(ADRA-International.) Its structure consists of country offices including one in Blantyre (ADRA-Malawi). The Child Survival Project was largely funded by USAID as well as matching funds provided by ADRA-I, ADRA-Malawi, the SDA church, and other NGOs. The project office is in Ngabu in the Lower Shire Valley.

The project, implemented by ADRA, is located in the Nsanje District, in the extreme southern tip of Malawi. The project covers the northern half of the district which was divided into two operational areas, one on the east bank of the Shire River and the other on the west bank as far south as Tengani.

1.1.2. History

The project began in October 1990. A manager was appointed and assumed responsibility in early December 1990. All supervisory personnel were selected and trained during the first project year. Volunteers were trained beginning in the second year of the project. An advisory committee composed of representatives from MOH, IEF, ADRA, Trinity Hospital, TALRES and World Vision began meeting quarterly within the first six months of the project.

Initially, the project incorporated activities directed to all of the objectives plus the beginnings of a birth and death registry. With the arrival of the second project director in July 1992, a decision was made to focus more directly on a few key interventions. As these key interventions were well implanted, new ones were added.

1.1.3. Approach

Key interventions provided by the project, targeting mostly high-risk families, include immunization, control and management of diarrheal diseases, emphasizing oral rehydration therapy (ORT), child spacing (family planning), nutrition education including promotion of exclusive breastfeeding for babies until the age of four months, promotion of gardening for protective foods, vitamin A education, malaria prevention and intervention, sanitation (latrines), and HIV/AIDS education.

The project uses the MOH model: health surveillance assistants (HSA) supervise village-based activities that are carried out by village health volunteers (VHV) and

village health committees (VHC). Currently, the project is active in 157 villages. There are approximately 25 additional villages in the catchment area of which about 12 are either covered by the MOH or informally by the CS project.

1.1.4. Unanticipated Constraints

The most serious draught in sixty years affected the project region with severe food shortages from mid 1992 through the first trimester of 1993. ADRA participated on the Drought Relief Coordinating Committee. It was decided that ADRA would continue regular project activities while MSF carried out nutrition surveys and the Red Cross was responsible for food distribution. Although the program did continue it was hampered in many ways: Volunteers were not able to devote as much time to project activities because they had to find food for their families; some of the villagers moved temporarily to areas close to the river where they could cultivate which appears to have resulted in continued dislocation of some village populations; staff members spent more time collecting water for their own needs; the garden component lapsed in many places; diarrhea, including bloody diarrhea and cholera were prevalent due to the poor quality of water; many people did not have enough to eat; MOH resources were diverted to cholera camps resulting in a breakdown of the MOH distribution system and shortages of ORS and other medications throughout the region.

The project area is remote and underdeveloped. The location of the project office and project manager's residence is in a small town, Ngabu, which is outside the project area and has no amenities. The first manager did not have a house or a vehicle. A house was built for the second project manager but it is a poor house. Electricity in the office has been unreliable and two hard drives have crashed, resulting in significant losses of survey data. The project has never had good vehicles that were suitable for the terrain. There have been continuous problems with breakdowns of vehicles, motorcycles and bicycles.

There were serious delays in receiving funds from Washington which necessitated borrowing from ADRA/Malawi during the first six months or so of the project. The accounting system was not set up until well into the first year of the project and computer breakdowns closed down the system for a period.

When the new manager arrived the staff was demoralized as there had been two devaluations and their pay had not been increased although government salaries had been raised. The first two-year budget had been overspent.

1.2. Evaluation Methodology

The evaluation team included the team leader who was an outside evaluator, a member of the ADRA/I staff, two individuals from the Ministry of Health and two

members from local non-governmental agencies. (See Appendix A: Evaluation Team Members.)

The evaluation took place between August 3 - 13, 1992. The team met with all of the project staff, including the manager, supervisors and HSAs. The team visited ten project villages and talked with volunteers, village health committees and mothers. Guidelines for these interviews were developed to standardize the approach of all team members. (See Appendix C: Guidelines for Interviews.) The team also visited several MOH and non-governmental health centers and health posts in the project area. (See Appendix B: List of Interviews.)

The evaluation report includes the main body of the report which is a description and analysis of the project. Responses to the Sustainability Questions and Issues to be Addressed by the PVO Child Survival Project Final Evaluation Team appear as Appendix F to this report.

2. IMPLEMENTATION

2.1. Personnel

2.1.1. Project Manager

The current project manager arrived in July 1992 replacing the first manager who had to leave for personal and health reasons after 18 months. The project manager has worked under difficult conditions although the situation has improved somewhat, particularly since a used vehicle was purchased. However, the lack of reliable transport continues to be a problem.

The project office is situated in Ngabu, outside of the catchment area. However, it appears to be the best location given the relative accessibility to the project area and to Blantyre where the project manager must go regularly for meetings, provisions and to the local ADRA office. Ngabu also has electricity, telephones and a nearby guest house for visitors.

2.1.2. Project Supervisors

There are two project supervisors: one for the east bank and one for the west bank. It was planned that they should be health inspectors. However, neither of one of the original health inspectors was satisfactory -- one resigned in June and the second in

October 1992. One was replaced by a medical assistant and the other by the man who had been the gardening supervisor.

2.1.3. Health Surveillance Assistants (HSA)

Currently, there are 19 HSAs. The number of HSAs has varied between 10-12 on the east bank and between 8-9 on the west bank. Two HSAs (one in each sector; one male and one female) were terminated due to poor performance during the first year. They were both replaced by men. One HSA died in December 1992. The garden trainer living in the same area assumed some of the duties of an HSA and continued half-time with gardening activities. Two HSAs were laid off in May 1992 due to budget constraints and considering that their performance was weak. Their villages were divided among four other HSAs working in neighboring villages.

Each HSA supervises between 7 and 14 villages on the east bank and between 4 and 9 villages on the west bank. The villages on the east side are smaller in population and closer together. Those on the west side are larger and more spread out. The number of volunteers per village ranges from 1-12 with an average of 3. Each HSA supervises between 18-37 volunteers with an average of 23 volunteers per HSA.

At the very beginning of the project there was an effort to recruit an equal number of men and women. The educational qualification was comparable to the MOH requirement -- a Standard 8 education. With more experience, it has become apparent that, in general, more education is beneficial and a high proportion of HSAs now have Form 2.

With an emphasis on higher educational status, it is more difficult to recruit qualified women because the educational standards of women in Malawi are significantly lower. All but two of the female HSAs have only a Standard 8 education while all but two of the men have completed Form 2. The women tend to be absent more than the men: three female HSAs had fairly long maternity leaves and the women periodically have to care for their sick children. Six of the women do not have the physical stamina necessary to cycle long distances while only one of the men had this problem (and he died). Therefore, in general, female HSAs need to be posted in smaller catchment areas where they are not required to travel too far.

2.1.4. Village Health Volunteers (VHC)

At present there are 432 volunteers working in 157 villages. The maximum number of volunteers was 500. Of those currently involved, most have been with the project since the beginning. Among those who have dropped out at least 8 have died. Other reasons given were that some women married and moved away or their husbands did not want them to continue. A fair number of volunteers dropped out, especially during the draught, because they had to devote themselves to finding food for their families.

It appears that most volunteers were recruited by their village chiefs. Based on the anecdotal evidence gathered by the evaluation team in interviews with the VHCs, HSAs and others, most of the VHVs are enthusiastic about the work. They say that it has helped them to understand better sanitary and health practices, including the importance of latrines and how to manage diarrhea, cholera and malaria. One woman said that she learned how to utilize readily available foods to provide good nourishment to her children; one man said that he used to go to hospital for every illness but now knew how to manage some health problems at home.

The volunteers are happy to be able to help their communities and to provide mothers with the knowledge of good breastfeeding, nutrition and oral rehydration practices. They maintain supplies of ORS in their homes and are called upon when ORS is needed. The communities appreciate the volunteers and particularly having access to ORS in the village. It is interesting to note that there are not many other, if any, community development volunteers in project villages which could account for some of the apparent success of the health volunteers.

Volunteers usually work part of one or two days per week and are "on call" at all times. They visit high risk families in their homes, meet with groups in the community and assist at the under five clinics. Between August 1992 and July 1993 volunteers reported visiting an average of 67% of high risk families at least once per month; statistics for the last six months only indicate over 80% of high risk families were visited monthly.

Initially, a high risk family was defined as an family with a child under three years of age or a pregnant women. As this included about 80% of all families, the definition was further refined. A high risk family is one with two children under three or a pregnant woman and a child under three which includes approximately 40% of families in the project area.

All volunteers on the east bank are literate and able to fill out their simple monthly reports; not all are literate on the west bank although they are able to find someone to do their reports. Over the last year an average of 88% of volunteer reports were submitted monthly.

There are no statistics on the distribution of men and women volunteers. Among those villages visited, there were both. Based on the team's observations, there appears to be a tendency for the women to work more closely with women on breastfeeding, for example, and for men to be more involved in sanitation.

Initially, VHVs received a uniform and badge. Some claim that they were assured of additional incentives at the beginning of the project. However, they have not received incentives, with the exception of one distribution of soap which was frowned upon by the MOH. In fact, they have not even been given expenses to

attend monthly group meetings/in-service training sessions until the last few months when they received a small amount. This seems to have been a tremendous morale booster and increased attendance at the sessions considerably.

It is currently the policy of both governmental and non-government organizations in Malawi not to compensate volunteers. However, since the referendum, there appears to be a new attitude toward volunteerism. The new parties have campaigned on promises of a brighter economic future which has encouraged people to believe that they can be paid for their work. The MSF volunteers went on strike recently. ADRA has participated in an IEF-sponsored study of VHVs in Malawi. It is hoped that the results will provide some helpful insights to ADRA and perhaps for the entire country.

2.1.5. Village Health Committees (VHC)

There are presently 157 villages participating in the CS project and 150 trained VHCs. Most villages have had VHCs for many years that were instigated by the MOH. However, these committees were inactive until being reinvigorated by the HSAs, starting in January 1993. The VHCs were chosen by the chief and the community. Training was provided by the HSAs. VHC members tend to be elders of the village and they tend to be less educated than the volunteers. In most villages the VCVs are not members of the VHCs although they work closely together. Volunteers appear to appreciate the support they get from the VHCs, especially in aggressively promoting pit latrines. Several volunteers indicated that they felt it was unfair that the VHC was given a book (the UNICEF publication "Facts for Life") while they have been working for almost three years without receiving anything of this nature.

2.2. Training

2.2.1. HSA Training

The HSAs were trained initially for a nine week period from May - July 1991. This training included the six-week MOH syllabus for HSA training and an additional three weeks of specialized training in vitamin A, nutrition, leprosy and in the operations of the project, including record keeping and reporting.

During the first year following the initial training, there were regular quarterly refresher courses of two to three days each. Since September 1992, the refresher training has been integrated into the monthly meetings held with all HSAs, the project manager and supervisors. (See Appendix D: : Topics for Monthly HSA Training.) In addition, during the period December 1992 - February 1993, an expatriate volunteer provided intensive weekly training, primarily in breastfeeding, for east bank HSAs and monthly training for all HSAs in breastfeeding, family planning, didactic and drama techniques.

Although the initial training was considerably broader than the focus of the project, it appears that the HSAs obtained a good grounding in basic health issues, giving them some confidence in their ability to supervise and deliver basic health services. With the addition of breastfeeding as a major component of the project, the HSAs were specially trained, enabling them to train the volunteers. For subjects that have not been a part of the project but are integrated into other health programs, for example, bilharzia, a knowledge of the disease and prevention strategies enables the HSAs to participate fully in and contribute to the ongoing program of the MOH.

The project manager believed that the HSA training had emphasized a more technical disease-model approach rather than health promotion and disease prevention. Thus the in-service training has emphasized the prevention and treatment of common problems.

According to the observations of the evaluation team, the HSAs appear to have a good knowledge of relevant information. The HSAs also appear to have been well trained in supervision and on-the-job training of volunteers. They understand the importance of constructive supervision and positive reinforcement and the strategy of observing the performance of volunteers and commenting afterwards.

2.2.2. VHV Training

The VHVs were trained initially for three days in project interventions: nutrition and growth monitoring, immunization promotion, the control and management of diarrhea and the management of malaria. They have received refresher and new training from the HSAs during their monthly meetings. Subsequent training has included: sanitation, particularly pit latrines, vitamin A, particularly capsule distribution, breastfeeding and family planning.

Based on interviews with volunteers and mothers, it appears that the VHVs understand the principles of the primary interventions and are able to transmit information to the mothers.

2.2.3. VHC Training

The village health committees were trained for one day by the HSAs in sanitation, cleanliness of the village and the other project interventions. The training was conducted, two villages at a time, with an average of two trainings a week, beginning in September 1992. In the last few months, this training was accelerated to ensure that all VHCs were trained before the project ended.

The VHCs appear to be knowledgeable, especially about the importance of latrines and cleanliness, including the use of dish racks and sweeping.

2.3. Supervision

Supervision at all levels has been a major emphasis of this project. The supervisors and the HSAs each develop their own monthly work plans. The project manager and the supervisors have copies of the work plans and are able to verify the degree to which they are followed.

The project manager meets regularly, at least twice per month, with the two supervisors. She stays abreast of the activities of their HSAs by frequent discussions with the supervisors and visits to the HSAs, and by reviewing monthly reports carefully.

The reports indicate that each supervisor meets with every HSA in his sector at least once a month barring illness or leave and that they receive monthly reports from the HSAs with the same regularity. Each of the supervisors has a motorcycle, enabling him to move easily around the sector. In addition to the monthly group meetings of HSAs, the supervisors regularly meet the HSAs in the field. The supervisors appear to have an intimate knowledge of the activities of each of their HSAs and of the overall programs within their sectors.

HSAs supervise their volunteers closely. Most villages are within a two-hour bicycle ride of the HSA's base and each HSA is provided with a push bicycle and spare parts by the project. The monthly group meetings of volunteers are well attended and the HSAs meet volunteers when they assist with under five clinics and when they visit the villages. There is a major emphasis on having the HSAs visit high risk families in the villages: this involves the HSAs directly in the community-based activities, provides an opportunity for the HSAs to supervise closely the work of the volunteers and it helps to reinforce the work of the volunteers with these families.

The overall statistics indicate that between August 1992 and July 1993, on average 85% of volunteers were visited at least monthly. All of the volunteers with whom the evaluation team met reported having regular contact with the HSA once or twice a month. The HSAs also appear to be knowledgeable about the activities of their villages and VHVs.

2.4. Gardening Activities

The garden component has been implemented by a garden supervisor and two garden trainers. The garden supervisor became the west bank supervisor in November 1992 but continued oversight responsibility. One of the trainers, a woman, resigned and was replaced by a man. (There were no female applicants.) In the last year both garden trainers moved to the west bank as the ADD is more active in the east bank and can follow up, providing seeds and technical assistance.

The gardening activities are not generally integrated with the rest of the CS project although they are carried out in project villages, reinforcing nutrition and vitamin A messages and helping villagers to provide food for their families. Thus the garden trainers work directly in the villages. Three HSAs in the more remote areas on the west bank have been trained in gardening.

In the first year of the project, demonstration gardens were established in 3 villages in the west bank and 3 villages in the east bank. Gardening techniques were demonstrated to the villagers for application by individual families in their own gardens. The demonstration gardens were quite productive. Some of the offtake was distributed among high risk families and some sold to raise funds.

The second year a different approach was used. Fenced communal gardens were developed in which individual families cultivate their own plots. This concept has the advantages of locating family plots where there is the best access to water and sharing of watering cans, rakes and hoes which are provided by the project.

Currently there are about 7 villages in the east bank with communal gardens and 20 in the west bank.

2.5. Special Activities

2.5.1. Vitamin A

In collaboration with the IEF, the CS project became involved in vitamin A activities: education on vitamin A-rich foods and capsule distribution. Training of HSAs and volunteers began in early 1992. There were three capsule distributions to children between 3 months and 6 years of age and breastfeeding mothers of children under 3 months: June and December 1992 and June 1993. Approximately 8,500 capsules were distributed in the first distribution, 13,800 in the second and 15,700 in the third. The second distribution reached approximately 87% of the target population and the third, which included a larger area, reached approximately 79% of the target population.

2.5.2. Revolving Drug Funds

In the last year of the project 3 HSAs in remote areas were given supplies of aspirin and chloroquine to sell at a small cost. During the cholera epidemic antibiotics were added. The MOH has not been supportive of ADRA's operating revolving drug funds, especially when antibiotics were included.

Overall more than 6000 aspirins and 3500 chloroquine tablets have been sold. The availability of drugs in the remote areas appears to be appreciated, however, there is a fair management burden on the project manager.

2.6. Coordination with Other Organizations

There is strong coordination with the Ministry of Health (MOH). The classifications of personnel, their training and the organization of village-based volunteers and activities correspond precisely to the MOH structure. Wherever possible, the project personnel work together with the MOH: ADRA HSAs are regularly scheduled to participate in both static and mobile under five clinics and ADRA HSAs supervise and train volunteers and VHCs organized by the MOH. ADRA is presently supporting the building of a new health center for the MOH in a remote area served by the project (with monies from the Ambassador's self help fund). ADRA has planned new family planning and AIDS prevention activities to coincide with the MOH strategy.

The major constraint in this collaboration is that ADRA relies totally on MOH clinic services and supplies. Frequently supplies, such as ORS, are out of stock in the local warehouse. ADRA then must apply at the warehouse in Blantyre or be otherwise resourceful in obtaining the supplies from the MOH. Sometimes stationary clinics are out of vaccines and mobile clinics are canceled because the MOH HSAs' bicycles need repair. ADRA has, on occasion, provided spare parts for the bicycles and has facilitated the clinics' obtaining essential vaccines and other supplies from the MOH warehouse.

The project has had excellent collaboration with other PVOs in the region. ADRA was a full participant in the local draught committee. The CS project works closely with Trinity Hospital that has had outreach activities in the area for years and there is mutual agreement that project HSAs supervise VHCs and volunteers in communities in which Trinity is active. ADRA and the International Eye Foundation (IEF) have trained HSAs for each other and ADRA collaborated with the IEF study of VHVs. The CS project has also been active in IEF vitamin A activities. There are joint health promotion activities with TALRES. The gardening supervisor works closely with the ADD.

2.7. Technical Assistance

2.7.1. List of Technical Assistance Activities

The project has benefitted from technical assistance from a number of sources, both from within Malawi and from elsewhere:

- Health Information Systems, CS Program of Save the Children, Mbalachanda, Malawi.
- HIS and Household Survey, Center for Social Research, University of Malawi.

- Training of Volunteers, Community Health Services, Malamulo Hospital
- Coordination of Training Health Surveillance Assistants, MOH Region and District
- Nutrition in Children in Malawi, Blantyre Adventist Hospital
- Development of DIP, Dr. Bill Dysinger, ADRA/I
- Literacy Testing for HSAs, Primary School Teacher, Makwasa
- Program Coordination, High-risk indicators, ADRA/I
- Training of Trainers, Victoria Graham, ADRA/I
- Malaria Intervention, London School of Tropical Medicine and Bridge International
- Agronomy, World Vision International, Blantyre
- HIS, Hubert Allen Associates
- HIS, private consultant, Blantyre
- HIS, Dr. Lester Wright, Loma Linda University
- Training of HSAs, Ms. Gladys Martin, Volunteer
- Strategic planning, Dr. Floyd Murdoch, ADRA/I

2.7.2. Perceived Value of Technical Assistance

Considerable TA has been used by the project. According to project staff, the TA provided by ADRA/I as well as that provided by others, has been very useful in orienting project staff to the local conditions and situation as well as to assisting in specific areas. Much of the TA has come from within Malawi. That is positive, since many of those who have provided it remain available to continue their assistance.

There have been some areas in which the project manager would have liked TA and the TA that is programmed is not always timely. It would be useful to the project if the manager had some flexibility in identifying the timing and nature of TA needs.

3. ACHIEVEMENTS

3.1. Measurement of Achievements

Initial baseline data for measuring each of the objectives were to have been collected by the volunteers on their monthly reporting forms. However, these data were not considered reliable for a number of reasons involving both the recording and the reporting of information. Therefore, there were no baseline data.

Analysis of the achievement of most of the objectives is based on two cluster sample surveys. The first survey in August 1992 was based on 8 households in each of 30 villages. The second cluster survey is a subset of a larger survey done in June 1993 which was a sample of 848 households based on approximately 30 households in each of 30 randomly chosen villages. (There were 519 households in 19 villages on the east bank and 329 households in 11 villages in the west bank.) The subset was drawn by including only the first 8 households in each village. In comparing these with a more random subset, it appeared to be a reasonable sample. The subset was used as the comparison with the August 1992 survey because it was thought be more comparable than the full survey. However, the desegregated data from the full survey for the east and west banks are useful to point up differences in the two sectors.

Both surveys are considered to be reasonably reliable: they were conducted by competent researchers and the results have been corroborated by other information.

The midterm cluster survey was tabulated and analyzed in the Blantyre ADRA office because the computer in the Ngabu office crashed during the initial data entry. The data-entry clerk had to work overtime and space was small; quality control was less difficult. The second cluster survey was analyzed in the Ngabu office with better quality control.

An additional survey was carried out in June 1992 which included 80 households in 10 villages in which there are no HSAs or project-supervised volunteers.

Measuring the achievement of several of the objectives is based on the monthly reports submitted by the volunteers. The frequency of reporting from volunteers is very high and is considered reasonably reliable, especially since these reports were simplified. The level of supervision by the HSAs and HSA involvement in visiting high risk families in the villages increase confidence in the information.

3.2. Achievement of Objectives

3.2.1. Eighty percent of 0-36 month old children will be fully immunized (The working definition was children between 12 and 23 months having received BCG, DPT 1, 2 & 3, polio 1, 2 & 3, and measles vaccinations.)

Both the first and second cluster surveys found that 83% of children in the project area were fully immunized with the second large survey indicating that 85% of children were fully immunized, 89% in the east bank and 81% in the west bank. The separate survey of households in villages with no project activities found 97% of children fully immunized!

Explanations for lower rates in the west bank include: a shortage of vaccines in MOH clinics, the lack of bicycle spares for MOH HSAs, the unreliability of MOH mobile clinics, less accessibility to both mobile and static clinics due to longer distances and poor roads.

The results of the survey in non-project villages appear to be related to the fact that the sample was very small and resident near a health clinic.

3.1.2. Eighty percent of children under age three will receive appropriate ORT (In case of diarrhea children under age 3 will be given ORS.)

The summary of the monthly reports for the period August 1992 to July 1993 indicates that, on average, 85% of children with diarrhea were treated with ORS.

The constraints include periodic stockouts of ORS and spoiled packages of ORS. Although the HSAs and the volunteers appear to know about homemade ORS and maize gruel, apparently they are not well accepted. This may be because of the lack of ingredients for ORS and a high acceptability of ORS as "medicine".

3.1.3. Eighty percent of high risk families will be receiving biweekly home visits from about 450 volunteers (A high risk family is defined as one with either two children under 3 years of age or a pregnant woman and a child under 3 years.)

The summary of the monthly reports for the period August 1992 to July 1993 indicates that, on average, 67% of high risk families were visited twice monthly by volunteers and 54% were visited once by HSAs. However, there has been a steady increase since September 1992 with significantly higher rates in more recent months: in June it was reported that 78% were visited twice by volunteers and 74% once by HSAs; in May 73% by volunteers and 64% by HSAs; in April 80% by volunteers and 70% by HSAs.

3.1.4. Sixty percent will be appropriately using a latrine for human waste disposal (Since use is too difficult to measure, this was redefined as households having a latrine.)

The August 1992 cluster survey found 62% of households had a latrine; the June 1993 cluster survey found 50%. The survey of non-project villages found 35% of households having a latrine.

The reduction of latrines may be attributed in part to the recent torrential rains which washed out numerous latrines in the project area. In the last few months, there has been a significant increase in digging pit latrines since the training of the VHCs and the distribution of picks, shovels and buckets to the VHCs (provided under separate ADRA funding).

3.1.5. Seventy percent of mothers will be breastfeeding as the only food for their infants for at least the first four months following birth

Between the first and second cluster surveys there was an increase from 4% to 6% of mothers breastfeeding exclusively for the first four months, far short of the target. However, these data are better than the 0 - 2% of women breastfeeding exclusively found in a recent non-project related survey in the southern Malawi region and the 0% in the survey non-project villages. It is hoped that with the intensive training early in the year, and what appears to be high levels of knowledge among HSAs and volunteers, practices in the villages will change. However, traditional beliefs and behaviors, combined with the demands on village women to work in the fields, mitigate against dramatic improvements. Nonetheless, anecdotal evidence indicates there may be changes in other breastfeeding behaviors such as giving the first milk to newborns.

3.1.6. The percentage of severely malnourished children under the age of three will have been reduced from its current estimated ten percent to less than five percent

For purposes of the cluster surveys, severe malnutrition was defined as either three consecutive months with no growth or two consecutive months with weight loss as recorded on the child's growth chart.

The first cluster survey found 30% of children met the criteria for malnourishment and the second survey found 14%. Since the definition of "severe malnutrition" is completely different than that commonly used, the statistics are meaningless in terms of the objective. Moreover, project activities are not likely to be able to affect rates of severe malnutrition so this is not a good indicator of project achievement.

3.1.7. There will be a fifty percent increase from the current use in the utilization of modern family planning by eligible couples

The first cluster survey found no child spacing and the second found 9% of respondents reported practicing a child spacing method. Only 1% of respondents in the non-project villages reported practicing. There were no baseline data with which to compare.

Child spacing was not addressed until very late in the project. Family planning was not considered a priority by some country and division level staff. However, recently, HSAs and volunteers have been trained in family planning education. Project staff were ready to implement a major family planning education effort but the MOH regional office asked ADRA to wait until the new CBD program begins

A nurse/midwife from the project participated in the training for CBD that was given for staffs of governmental and non-governmental organizations. The CS project is awaiting the new funding period to begin CBD activities in collaboration with the MOH.

3.1.8. Thirty percent of households in the project will have a home garden growing at least five different nutritionally rich foods for home consumption

This was defined as the presence of a garden producing vitamin A rich foods which could be seen growing near the household.

In the first survey 26% of households were found to have a garden and in the second only 14%. In the non-project villages 4% of households had a garden. However, this is not an appropriate measure of the gardening component as gardens are planted where there is access to water and in many of the project villages these gardens are not near the homes.

The second cluster sample was after the draught when many villagers moved away from their villages into more marshy areas to cultivate.

3.1.8. Fevers (presumed from malaria) will be reduced in mothers and three aged children by forty percent in the targeted malaria project

Fever in children under three is reported monthly by the volunteers. The reported incidence of fever fluctuates with a low of under 20% reported in October 1992 and a high of almost 40% reported in January and February 1993.

There are no baseline data for this objective. However, as the malaria project has not begun and the primary malaria intervention is presumptive treatment, the project could not be expected to have had an effect on prevention. ADRA is planning to participate in the pilot treated bednet study and has submitted a new proposal. It is

hoped that approximately one-third of the project area (probably on the west bank) will be included in the pilot.

3.2. Unintended Benefits

The development within the project area of a viable network of trained HSAs and volunteers has provided an infrastructure for introducing additional activities that contribute to the health and welfare of project beneficiaries, such as vitamin A education and capsule distribution. The CS project will be participating in a pilot CBD family planning effort in collaboration with the MOH. Separate funds have been attracted for a malaria prevention/ bednet pilot project and proposals are under consideration for adult literacy activities. ADRA raised $13,000 from the Ambassador's Self-Help Fund to build a health post for the MOH. In addition, the project has been able to attract and support other activities in the project area, such as the ADRA water project. World Vision is planning a project in the area that will utilize the CS infrastructure and a new UNDP-funded project to support income generating activities is under consideration.

3.3. Sustainability

The project was designed to strengthen the MOH community-based primary health care and child survival program. Thus the project utilized the MOH model based on HSAs, volunteers and VHCs. Therefore, the project is inherently sustainable, to the extent that the MOH is able to support its own program. However, given the serious financial constraints of all government budgets within the near future, it is unrealistic to think that if ADRA were to leave at the end of CSVI, the current level of project activity would continue.

If there were to be no follow-on project, there are other NGOs working in the project area that might engage some of the trained project staff to do the same or similar types of activities. IEF has already indicated that they might be able to provide bridge funding to support HSAs until CSIX begins. IEF, possibly World Vision, Trinity Hospital, Kalemba Parish or other organizations, might well recruit staff in the absence of ADRA.

There are some elements of the project that would continue if all outside funding were ended. The HSAs have been trained in project interventions and have good experience in implementation and supervision of volunteer programs in the villages. Even if these HSAs were not taken on by the MOH or another NGO, the evaluation team believes that most of these individuals would continue as health agents in their own communities. The volunteers, mothers and other members of the community have increased knowledge and the extent to which their behaviors have changed will continue.

The experience with cost recovery in this project has not been sufficient to evaluate the potential for eventual development of a similar activity that is self-financing. The MOH has incorporated concepts of service fees and the sale of medicines into the next five-year plan. Experience with the family planning CBD program and, perhaps, an expansion of the revolving drug fund concept in CSIX may provide the basis for more sustainability in the future.

4. FUTURE ISSUES

4.1. Lessons Learned

4.1.1. Building the Infrastructure

Building the infrastructure for a community-based health program is resource intensive and slow.

4.1.2. Supervision

Effective supervision is the most critical element of a community-based health program, particularly one that depends on volunteers. Regular, supportive supervision at all levels of this project is the most important factor in sustaining the performance of all members of the project team. Supervision is necessary to maintain the morale of the personnel, especially volunteers and those working in relative isolation. Supervision is also necessary to maintaining standards of service delivery, particularly in this project in which a significant part of the supervisory activity is essentially on-the-job training.

4.1.3. Credibility of Volunteers

Volunteers must be performing a service that is perceived as being valuable to sustain their enthusiasm. In this project the volunteers perceive the knowledge they have gained to have helped them in caring for their own families. They also provide education and, more tangibly, ORS, which gives them credibility in the community.

4.1.4. Availability of Health Services

Since the direct services that can be offered by the volunteers are limited, the availability of vaccinations and accessibility to curative services is essential.

4.1.5. Effective Leadership

Strong, engaged project management is necessary to keep the project energized at all levels.

4.1.6. Relatively Small Project

This project is small enough so that the project manager and the supervisors have a good knowledge of every HSA's performance and of the strengths and weaknesses of the program at every level. This enables them to provide close supervision at all levels and to make adjustments rather quickly.

4.1.7. Parallels MOH Structure

As the structure of the project is designed to mimic that of the MOH, it is well integrated with the ongoing program. Thus the project and the existing program are mutually reinforcing and the prospects for sustainability are greater.

4.1.8. Collaboration with NGOs

Collaboration with other NGOs has strengthened the program as the CS project has benefitted from their experience in the project communities (e.g.Trinity) and their specialized expertise (e.g. IEF). There have also been mutual benefits from joint activities, such as training, enabling both NGOs to save scarce project resources.

4.1.9. Relative Importance of Health as a Development Activity

The relative importance of health as a development activity in project communities and the fact that, for the most part, volunteers do not have other volunteer responsibilities, results in more support for project activities.

4.1.10. Value of an Effective Infrastructure

Building an effective infrastructure with good communication and outreach can be utilized for activities that are not directly project related (e.g. vitamin A capsule distribution) as well as the basis for new activities (e.g. breastfeeding).

4.1.11. Focused Objectives

The objectives of this project were too diverse, especially for the start-up period. Fewer, more focused objectives will direct project implementation efforts more effectively. Additional objectives can be added later, or even built into the original project design, if there is a plan for gradual phasing after initial activities are well implanted and are beginning to show results.

4.1.12. Educational Qualification

A minimum of Form 2 education is a requisite for the quality of work expected of the HSAs.

4.1.13. Simple Data Collection Instruments

Simple reporting forms requiring the minimum of information necessary result in more reliable and regular reports. They are more useful for management at all levels. Simpler forms require less time to complete and to analyze resulting in less time being diverted from direct service and supervision.

4.1.14. On-the-job Training

Training that is integrated into regular supervision is a critical complement to more formal refresher training. It reinforces the training and helps both the supervisor and the supervisee to understand practical application of the training.

4.1.15. Data Entry and Analysis

The quality control is significantly improved if data entry and analysis is done at project headquarters rather than being farmed out.

4.1.16. Pit Latrines

Unlined pit latrines wash out in heavy rains, especially in the riverain and sandy areas. This is discouraging for the villagers. Moreover, each new latrine must be dug in a new place which can be a problem on individual compounds.

4.2. Recommendations for the Follow-on Child Survival Project

4.2.1. Continuation

The project should continue within the same catchment area, utilizing the same basic approach.

4.2.2. HSA Organization

The project manager's concept of grouping HSAs into pods of 3-5 should be introduced. Each pod would include a senior HSA and a mix of women and men. Each HSA should have a special area of expertise in addition to his/her general knowledge and to that within the pod they can provide support to each other. These special areas will be the areas of emphasis for the new project, e.g. family planning, AIDS prevention, breastfeeding, diarrhea management.

4.2.3. Project Objectives

Project objectives should be limited to a few that will serve to focus the activities. Additional objectives can be added or planned to be phased in as the project

progresses. There should be flexibility to amend project objectives in the event that circumstances change.

4.2.4. Cost Recovery

Experimentation with cost recovery should be expanded in order to increase the potential for sustainability and to provide basic medications within the community, especially in outlying areas.

4.2.5. Volunteer Incentives

The project should not introduce monetary or in-kind incentives for the volunteers. However, they should be given more durable badges, preferably generic health volunteer/ health promotor badges that could be used by the MOH and other NGOs. There should be more small group meetings/training sessions for volunteers with small per diems provided to cover their costs. It is also possible that some monetary gain may be had from the sale of medications and contraceptives.

4.2.6. CBD

To the extent possible, existing volunteers should be utilized for the family planning CBD program to build on their experience and credibility in the community and to encourage them to expand their activities.

4.2.7. Transport

The project should have reliable transport at all times that is suitable for the project area.

4.2.8. Pit Latrines

Techniques of lining pit latrines should be introduced into the project area. (The Chief Technical Advisor, Ministry of Local Government should be used to provide technical assistance.)

4.2.9. Technical Assistance

The project manager should have some flexibility in identifying the needs for technical assistance, both in terms of timing and the nature of the technical assistance.

4.2.10 Project Manager

Given the isolation of project headquarters and the absence of opportunities in the area, ADRA should ensure that the spouse of the project manager has employment.

APPENDIX A: MEMBERS OF THE EVALUATION TEAM:

Ms Betsy Stephens, International Science & Technology Institute, Inc (ISTI)

Dr. Gerard Latchman, ADRA International

Dr. Angela Van Der Endt, Ministry of Health

Dr. Peter Cuppen, Trinity Hospital

Mr. Mkandawire, Ministry of Health

Mr. P. Katumbi, Shire Valley Leprosy Project

APPENDIX B: LIST OF INTERVIEWS

Both ADRA Supervisors

All 21 ADRA HSAs and one garden trainer

Ms. Gloria Khunga, Regional Family Health Officer, Ministry of Health

Staff, Masenjere Health Center

Sr Maria Virgo Lammers, Woman in Development Programme, Trinity Hospital

Chief Ng'ombe from Ng'ombe Village
VHC Members from the Ng'ombe Village
Volunteers from Ng'ombe Village

Chief from Sikeyi Village
VHC Members from the Sikeyi Village
Volunteers from the Sikeyi Village

Chief from Buleya Village
VHC Members from Beluya Village
Volunteers from Beluya

Chief from Masanzo Village
VHC Members from Masanzo Village
Volunteers From Masanzo Village

Chief from Chinekwe village
VHC members from Chinekwe village
Volunteers from Chinekwe village

Sister Clara, Nurse In Charge, Kalemba Clinic

Tengani Health Center

Chief from Reno Village
VHC Members from Reno Village
Volunteers from Reno Village

Chief from Tambo village
VHC members from Tambo village
Volunteers from Tambo village

Chief from Nyangai village
VHC members from Nyangai village
Volunteers from Nyangai village

Staff of Phokera Health Post

Mpepe school garden

Chief from Nanchichi village
VHC members from Nanchichi village
volunteers from Nanchichi village

Chief from Kanyimbi village
VHC members from Hanyimbi village
Volunteers from Kanyimbi Village

Mr. Jim Wilson, UNDP Water and Sanitation Advisor, Ministry of Local Government, Lilongwe

Dr. Chiphangwi, Director of Malawi Medical School

APPENDIX C: GUIDELINES FOR INTERVIEWS

Village Health Committee

- how chosen
- role & adequacy of training
- activities, frequency of meetings
- relationship with volunteers
- role of volunteers
- problems and achievements
- future value

Volunteers

- how chosen, why did you volunteer
- role and responsibilities
- usefulness to mothers/ community
- support from supervisors and community/VHC
- adequacy of training
- problems
- future value

- How were you chosen?
- How long have you been with the project?
- Why are you doing this work?
- How much time do you spend doing this work? Do you have enough time to do everything you want to do?
- Do you think that you help people in your village? Do people appreciate your help?
- Did you learn all of the things you need to know to do your job well in your training? If not, explain. Have you had any other training that helps you do this work?
- How often do you see your supervisor? Is he/she helpful? In what way?

Mothers

- do you know your ADRA volunteers?
- how often do you meet a volunteer?
- what have you learned from the volunteer?
- has the volunteer helped you? how?
- preference for male/ female volunteer?
- what did you do the last time you child had diarrhea?

APPENDIX D: TOPICS FOR MONTHLY HSA TRAINING

DATE	TOPICS AND SPEAKER
Sep. 92	Clarifying Program Objectives (Dr. Cook)
Oct. 92	How to Develop a Workplan (Dr. Cook)
Nov. 92	Vitamin A (Mr. M'manga, IEF) Diarrhea Treatment (Ms Gladys Martin, expatriate volunteer)
Dec. 92	Maximizing One's Potential (Ms Cheryl Orser, primary school teacher) Importance of Teaching Family Planning (Ms Martin) Symposium on Teaching Successful Breastfeeding (Five East Bank HSAs)
Jan. 93	Leading Causes of Death in Children in Malawi (Skit by Six HSAs, Discussion led by Ms. Martin) How to Develop a Drama (Ms Martin) Skit on Family Planning (Skit written and given by three HSAs) How to Conduct the House by House Village Survey (Dr. Joy Cook) Report on IEF Breastfeeding Seminar (Mr. Davis Mchawa, West Sector Supervisor)
Feb. 93	Family Planning Skit Competition (Written and played by all HSAs in sets of three) Critique of Skits by Clarity of Health Message, Interesting Story Line, and Delivery (Mrs. Katumbi, nurse mid-wife) How Fear Affects Health Behavior (Mrs. Katumbi) Presentation of Health Teaching Notes, compilation of lessons given by Ms Martin to East Sector in weekly meetings. Explanation on how to use.
Mar. 93	How to Interpret and Use Results of Village Survey (Dr. Cook)

Apr. 93	How to Teach Volunteers to Teach the Importance of Sanitation (Mrs. Katumbi)
May 93	How to Teach Volunteers to Teach Signs, Symptoms, and Prevention of Sexually Transmitted Diseases (Mrs. Katumbi)
June 93	How to Teach Volunteers to Teach AIDS Prevention (Mrs. Katumbi) Importance of the Child Survival Objectives (Pastor Masoka, President of Malawi Seventh-day Adventists)

APPENDIX E ACTIONS TAKEN IN RESPONSE TO MID-TERM EVALUATION RECOMMENDATIONS

a) **A replacement for the departing Project Manager must be hired immediately if the success of the project is to be assured.**

The replacement for project manager arrived 11 July 92.

b) **Simple, readily ascertainable specific indicators must be developed and collected for each of the project objectives. Examples of the type envisaged can be found in the section on Program Objectives. Much of the monitoring data can be collected by cluster sample rather than requiring area-wide collection.**

A simple cluster survey covering 6 objectives was conducted in August 92 and again in July 93. Two objectives are monitored monthly since they are seasonal.

c) **"High Risk" should be redefined so that project interventions can be focused on those at highest risk rather than on all families that include a child under three years of age or a pregnant woman. Families in the general population can be visited less often and those at "high risk" can be visited more often.**

High risk was redefined to equal roughly 40% of the households. High risk was defined as woman with more than one child under three or a pregnant women with a child under three.

d) **Data collection should be simplified and greatly decreased in volume and frequency. This will make it likely that the volunteers collecting the data will find it a manageable task and will allow for quality control checking of the data by supervisors at each level.**

Volunteer forms were reduced to four questions on one page monthly. Data were checked by HSAs and spot-checked by supervisors and clerical staff on behalf of the manager.

e) **Structure should be designed to assure that supervisors' visits are made at all levels of the project according to a designated schedule.**

Supervisors met 90% of their HSAs monthly. Supervisors met with the manager at least twice a month. The manager made occasional visits to HSAs.

f) **Regular in-service training of project HSAs and volunteers on topics such as 1) reason for home visits and 2) appropriate ORT must continue.**

The expatriate volunteer, Gladys Martin, spent considerable time teaching HSAs about ORT and how to conduct health education (once per week for 12 weeks for the east sector HSAs plus the once per/month class for HSAs from both sectors together).

g) **A schedule of needed technical assistance should be developed as soon as possible after new Project Manager is in place.**

Dr. Wright came twice for technical assistance. One time assistance was given by Dr. Murdoch. Other support was provided to the accounting office in Blantyre.

h) **The health information system should be simplified to collect only those items needed for operating and monitoring the project.**

The health information system was simplified (as described above in sections b and d).

i) **A birth/death register would provide much useful information for planning health programs. Project staff and Ministry of Health staff are interested in attempting a pilot of such a scheme in some part of the country. With the infrastructure in place in the project area, this could be the place to try it. A project proposal for this should be developed and funding to implement it should be sought.**

Funding for a birth/death register has not been formally sought but Community Health Science Unit/USAID has shown interest in the project.

j) **Training of Village Health Committees should be done as soon as possible to capitalize on the interest of members and establish a supportive group to work with and help guide volunteers. These committees are most critical to sustainability.**

All 157 Village Health Committee (VHCs) have had the one day initial training (except 3 villages who had other priorities such as a funeral on the scheduled day).

k) **Focus on health promotion and disease prevention must not be lost in trying to met the requests of the villagers for the volunteers to have a wider range of basic medicines available.**

Villages, volunteers and VHCs continue to ask for more medicines. They see ORS as medicine so do not understand why we have refused to expand.

l) **Provision of some basic medications through the volunteers with replenishment through a revolving drug fund (excluding the idea of profit for the volunteers) should be tried where interest and readiness is apparent.**

A revolving drug fund was attempted in 4 remote areas. It was abandoned in one place after a few months when the HSA had maternity leave. In the other 3 areas it has been popular.

m) **An inventory and supply system should be built into supervision so that those basic medications that are to be available (such as ORS) are indeed available.**

The MoH does not have an inventory and supply system that make it possible for ORS and lime (to purify water) to be available on a continuing basis.

n) **Incentives for volunteers need to be carefully developed in consultation with MoH officials and designed to encourage sustainability.**

The MoH has no resources to put toward incentives for volunteers. The volunteers, however, feel they should be given something. An acceptable compromise was reached by providing a very small per diem for short trainings.

o) **Coordination between the project and other primary health care providers in the area should include orientation of newly assigned staff and a system of more formal introduction to this ADRA project and its interventions. Opportunities for collaboration should be developed.**

The east sector supervisor visited all MoH staff on his side monthly with our monthly report. Additional collaboration has been informal.

p) **Linkages with workers in other sectors, e.g. home craft workers, should be strengthened. For example, villagers can be taught how to use vitamin A rich vegetables that can be grown in backyard gardens.**

The new home craft worker (wife of east sector supervisor) was unable to put much effort into the work due to personal problems.

q) **Reports developed by the project should be supplied to the relevant area primary health care providers as well as to the project management. These reports could form the basis for regular "team meetings" in the areas.**

Monthly reports were taken to each health facility in the area. Informal discussions were held with available staff at that time. This system was more formalized in the eastern sector.

r) **In order to make sustainability more likely, well defined written agreements should be obtained regarding future employment of the HSAs who are a vital supervisory link with the volunteers.**

The MoH is not in a financial position to be able make a commitment.

s) **If dependence on computers for data analysis is to be a feature of this project, then some degree of in-house computer expertise is needed in addition to the services of the consultant.**

The midterm cluster survey was tabulated and analyzed in the Blantyre ADRA office. The data-entry clerk had to work overtime and space was small; quality was less than had been hoped for. (It would have been done in Ngabu but the computer crashed during initial data entry). The final cluster survey was done in the Ngabu office with manager and clerical staff.

t) **Coordination of project activities with drought relief must occur.**

The manager attended monthly meetings of the DRCU at the RHO. The staff cooperated with MSF survey teams. The ADRA water project worked in collaboration with Concern Universal.

APPENDIX F: SUSTAINABILITY QUESTIONS AND ISSUES TO BE ADDRESSED BY THE PVO CHILD SURVIVAL PROJECT FINAL EVALUATION TEAM

A. Sustainability Status

A1 At what point does AID funding for the child survival project end?

August 31, 1992

A2 At what point does the organization plan to cease child survival project activities?

There will be a follow-on project.

A3 How have major project responsibilities and control been phased over to local institutions? If this has not been done, what are the plan and schedule?

NA

B. Estimated Recurrent Costs and Projected Revenues

B1. Identify the key child survival activities that project management perceives as most effective and would like to see sustained.

Diarrheal management, breastfeeding education, family planning.

B2. What expenditures will continue to be needed (i.e. recurrent costs) if these key child survival activities are to continue for at least three years after child survival funding ends?

Salaries of HSAs, HIs and regional MOH management.
Transport costs for supervision.
Per diems for training.

B3. What is the total amount of money in US dollars the project calculates will be needed each year to sustain the minimum of project benefits for three years after CS funding ends?

$100,000

B4. Are these costs reasonable given the environment in which the project operates? (e.g. local capacity to absorb cost per beneficiary)

Not under current circumstances.

B5. What are projected revenues in US dollars that appear likely to fund some child survival activities for at least three years after A.I.D. CS funding ends?

Follow-on project.

B6. Identify costs which are not likely to be sustainable.

Management, ratio of supervisors to HSAs, ratio of HSAs to volunteers/population, transportation for supervision and logistic support.

B7. Are there any lessons to be learned from this projection of costs and revenues that might be applicable to other child survival projects, or to A.I.D.'s support of those projects?

In countries in which the financial situation is as dire as Malawi, A.I.D. must continue funding.

C. Sustainability Plan

C1. Please identity number and position of project staff interviewed, and indicate the extent of their involvement in project design, implementation and/or monitoring/evaluation.

Interviewed 100% of project staff: 1 manager, 2 supervisors, 20 HSAs, 1 garden trainer and support staff.

C2. Briefly describe the project's plan for sustainability as laid out in the DIP, or other relevant A.I.D. reports.

There was a plan to train local workers to administer the project as expatriate management was phased out. Cost recovery, including a revolving fund for malaria suppressives, was also anticipated.

C3. Describe what sustainability-promoting activities were actually carried out by the PVO over the lifetime of the project.

The project was organized according to the MOH model, utilizing HSAs, volunteers and VHCs thus strengthening the MOH system. The project provided training and supervision to strengthen the village-based health care system.

C4. Indicate which aspects of the sustainability plan the PVO Implemented satisfactorily, and which steps were never initiated. Identify any activities which were unplanned, but formed an important aspect of the PVOs sustainability effort.

Cost recovery efforts were too small to have resulted in any significant effect.

Unplanned aspects: self-help funds were raised from the U.S. Embassy and the community to build a new health center and a new health post; World Vision is planning a project in the area that will utilize the infrastructure developed by the project.

C5. Did any counterpart institutions (MoH, development agencies, local NGOs, etc.), during the design of the project (proposal or DIP), make a financial commitment to sustain project benefits? If so, have these commitments been kept?

No.

C6. What are the reasons given for the success or failure of the counterpart institutions to keep their commitment?

NA

D. Monitoring and Evaluation of Sustainability

D1. List the indicators the project has used to track any achievements in sustainability outputs and/or outcomes.

NA

D2. Do these indicators show any accomplishments in sustainability?

NA

D3. What qualitative data does the PVO have indicating a change in the sustainability potential of project benefits?

If there were to be no follow-on project, there are other NGOs working in the project area that might engage some of the trained project staff to do the same or similar types of activities. IEF has already indicated that they might be able to provide bridge funding to CSIX. IEF, possibly World Vision, Trinity Hospital and Kalemba Parish or other organizations, might well recruit staff in the absence of ADRA.

There are some elements of the project that would continue if all outside funding were ended. The HSAs have been trained in project interventions and have good experience in implementation and supervision of volunteer programs in the villages. Even if these HSAs were not taken on by the MOH or another NGO, the evaluation team believes that most of these individuals would continue as health agents in their own communities. The volunteers, mothers and other members of the community have increased knowledge and the extent to which their behaviors have changed will continue.

D4. Identify in-country agencies who worked with the PVO on the design, implementation, or analysis of the midterm evaluation and this final evaluation.

MOH, Trinity Hospital, TALRES, IEF

D5. Did the PVO receive feedback on the recommendations regarding sustainability made by the technical reviewers of the proposal and DIP? Did the PVO carry out those recommendations? If not, why not?

The suggestion to reduce the catchment area was respected.

D6. Did the PVO carry out the recommendations regarding sustainability of the midterm evaluation team? If not, why not?

The recommendation that written agreement should be obtained from the MOH regarding future employment of HSAs was not done because of the financial situation of the MOH.

E. Community Participation

E1. Please identify community leaders interviewed and indicate which groups they represent.

The evaluation team interviewed chiefs, VHC members and party leaders from 10 villages in the project area. (See Appendix B: List of Interviews.)

E2. Which child survival activities do community leaders perceive as being effective at meeting current health needs?

Village sanitation and general cleanliness, vaccinations, ORS, gardening.

E3. What activities did the PVO carry out to enable the communities to better meet their basic needs and increase their ability to sustain effective child survival project activities?

The project trained volunteers and VHCs in 157 villages in diarrhea management, breastfeeding, sanitation, family planning and STDS/AIDS.

E4. How did communities participate in the design, implementation and/or evaluation of child survival activities?

Community leaders throughout the catchment area were involved in the design and planning. Also, area church leaders, traditional and political leaders were involved.

E5. What is the number of functioning health committees in the project area? How often has each met during the past six months? Please comment on whether committee members seem representative of their communities.

150 VHCs met approximately once per month.
Members appear to be representative of the leadership of the villages.

E6. What are the most significant issues currently being addressed by these health committees?

Sanitation and cleanliness of the villages, vaccinations, access to clinics, availability of medications in the village.

E7. What resources has the community contributed that will encourage continuation of project activities after donor funding ends?

They have contributed time to learn CS interventions; two have contributed labor and resources to build health posts; the community safeguards project resources, e.g. watering cans, ORS, training materials; epidemiologic surveillance, e.g. cholera outbreaks.

All participating villages have volunteers working with the project who, in general, work 1-2 days per week. They indicate that their volunteer activities have helped them to care for themselves and their families which should continue after the project ends.

E8. What are the reasons for the success or failure of the committees to contribute resources for continuation of effective project activities?

Communities have become involved because they perceive benefits, particularly from vaccinations, diarrhea management and sanitation activities.

F. Ability and Willingness of Counterpart Institutions to Sustain Activities

F1. Please identify persons interviewed and indicate their organization and relationship to the child survival project.

See Appendix B: List of Interviews

F2. What linkages exist between the child survival project and the activities of key health development agencies (local/municipal/district/provincial/state level)? Do these linkages involve any financial exchange?

The project uses the MOH model of community-based basic health services: health surveillance assistants (HSA) supervise village-based activities that are carried out by village health volunteers (VHV) and village health committees (VHC). The program adheres to MOH standards and the MOH provides oversight and technical support at every level. There has been no direct financial exchange.

F3. What are the key local institutions the PVO expects to take part in sustaining project activities?

The MOH and non-governmental organizations, including World Vision, IEF, TALRES.

F4. Which child survival project activities do MoH personnel and other staff in key local institutions perceive as being effective?

Diarrhea management, vaccinations, breastfeeding, family planning and sanitation. An overriding concern in the project area is accessibility to water.

F5. What did the PVO do to build skills of local MoH personnel or staff in key counterpart NGOs? Did they teach them to train CHWs, or manage child survival activities once A.I.D. funding terminates?

Local MOH personnel were invited to all training activities but seldom participated because the project did not offer special per diems.

F6. What is the current ability of the MoH or other relevant local institutions to provide the necessary financial, human, and material resources to sustain effective project activities once CS funding ends?

The MOH has limited resources. Other area NGOs, such as Trinity and World Vision, could pick up several of the project HSAs and supervisors.

F7. Are there any project activities that counterpart organizations perceive as effective?

The MOH has been very impressed with the project.

G. Project Expenditures

G1. Attach a pipeline analysis of project expenditures.

See attached.

G2. Compare the budget for planned expenditures identified in the DIP with the actual expenditures at the end of the project. Were some categories of expenditures much higher or lower than originally planned?

The expenditures in the procurement and program show some overrun, 3% for procurement and 2% for program.

In the procurement area, it is due to purchase of uniforms for volunteers that was not budgeted, as well as vehicles.

In the program area, the overspending is due to the doubling of the salary of the HSAs following a doubling of salaries of the MOH lowest echelon workers all over the country. The ADRA HSAs' increase was apportioned to them 2 months after the MOH increased the salaries of their HSAs.

G3. Did the project handle the finances in a competent manner?

Yes. The objectives were accomplished with funds that were available despite the following constraints: 1) Accounting personnel problem, lack of accounting expertise and system, computer breakdown, computer program limitation, and in the beginning, funds were being drawn out in an inconsistent way. However the project was on the whole carried out in a competent manner.

G4. Are there any lessons to be learned regarding project expenditures that might be helpful to other PVO projects, or relevant to A.I.D.'s support strategy?

a. ADRA's (or any PVO's) accounting mode should be on a prorated basis. Disbursements, especially support staff salaries should be consistently attributed to a given source and not different sources at different times. When wages are charged to the same place, it is more difficult to double dip.

b. PVO project managers should be aware of the imprest cash system from the very beginning. In this way it is easier to account for disbursement and monitor replenishment.

c. Major accounting problems are averted if key personnel are accounting literate. All key project personnel need an orientation in accounting and budgeting concepts.

d. If a standardized accounting system is adopted by the PVO worldwide, it has to make sure that it satisfies the highest common accounting factors in the countries in which it is operating.

e. The project accounting process is up and running from the very beginning when the PVO has made the effort to set up and test the system at headquarters before it is carried over to the field office.

f. When an accounting system covers only a one year period, it does not allow for computer verification of statements for dates prior to that year.

g. Inputs from project managers of other CS projects in the country at the time of a new CS project DIP elaboration allow for more precise estimates.

h. The person at headquarters responsible for disbursement of funds to the field CS program should always be accessible. If that person is travelling, a replacement facilitates requests from the field and prevents unwarranted delays.

H. Attempts to Increase Efficiency

H1. What strategies did the PVO implement to reduce costs, increase productivity, or make the project more efficient?

The project took a more conservative approach to spending after the midterm evaluation: cut down on trips to reduce transport costs and reviewed all requests for resources more carefully.

To increase productivity and efficiency, the project designed a different method of bicycle maintenance for the HSAs, establishing a "mobile bicycle repair clinic".

New motorcycles for the supervisor had to be purchased and regular maintenance provided.

H2. What are the reasons for the success or failure of the attempts to reduce costs, increase productivity or efficiency of this project?

More reliable transport for the supervisors and HSAs increased the regularity of supervision, on-the-job training and transport of essential supplies to the villages. However, while essential to increasing productivity and efficiency, these actions also increased operating costs.

H3. Are there any lessons to be learned regarding attempts to increase efficiency that might be applicable to other PVO child survival projects or to A.I.D.'s support of these projects?

Reliable transportation is critical to regular supervision and to efficient use of time of project staff.

I. Cost Recovery Attempts

I1. What specific cost-recovery mechanisms did the PVO implement to offset project expenditures? If cost recovery was part of the project, who managed implementation?

NA

I2. Estimate the dollar amount of cost recovery obtained during the project. What percent of project costs did this revenue cover? Did the cost recovery mechanisms generate enough money to justify the effort and funds required to implement the mechanisms?

NA

I3. What effect did any cost recovery activity have on the PVO's reputation in the community? Did the cost recovery venture result in any inequities in service delivery?

NA

I4. What are the reasons for the success or failure of the household income generating activities of this project?

NA

I5. Are there any lessons to be learned regarding cost recovery that might be applicable to other PVO child survival projects or to A.I.D.'s strategy?

NA

J. Household Income Generation

J1. Did the project implement any household income-generating activities?

NA

J2. Estimate the dollar amount of income added to a family or household's annual income, as a result of the income-generating activity of the project.

NA

J3. Did the revenues contribute to meeting the cost of health activities? What percentage of project costs did income generation cover?

NA

J4. Are there any lessons to be learned regarding household income generation that might be applicable to other PVO child survival projects or to A.I.D.'s support strategy?

NA

K. Summary

K1 Please give a brief (no more than one page), succinct summary of the responses to the previous questions concerning

- **the projects's accomplishments (in terms of outputs and/or outcomes) in enabling communities to meet their basic health needs, and in promoting sustainability of effective child survival activities.**
- **the project's competence in carrying out its sustainability promoting activities.**
- **any lessons to be learned regarding sustainability that might be applicable to other PVO child survival projects and/or relevant to A.I.D.'s support of these projects.**

The project was designed to strengthen the MOH community-based primary health care and child survival program. Thus the project utilized the MOH model based on HSAs, volunteers and VHCs. Therefore, the project is inherently sustainable, to the extent that the MOH is able to support its own program. However, given the serious financial constraints of all government budgets within the near future, it is unrealistic

to think that if ADRA were to leave at the end of CSVI, the current level of project activity would continue.

If there were to be no follow-on project, there are other NGOs working in the project area that might engage some of the trained project staff to do the same or similar types of activities. IEF has already indicated that they might be able to provide bridge funding to CSIX. IEF, possibly World Vision, Trinity Hospital and Kalemba Parish or other organizations, might well recruit staff in the absence of ADRA.

There are some elements of the project that would continue if all outside funding were ended. The HSAs have been trained in project interventions and have good experience in implementation and supervision of volunteer programs in the villages. Even if these HSAs were not taken on by the MOH or another NGO, the evaluation team believes that most of these individuals would continue as health agents in their own communities. The volunteers, mothers and other members of the community have increased knowledge and the extent to which their behaviors have changed will continue.

The experience with cost recovery in this project has not been sufficient to evaluate the potential for eventual development of a similar activity that is self-financing. The MOH has incorporated concepts of service fees and the sale of medicines into the next five-year plan. Experience with the family planning CBD program and, perhaps, an expansion of the revolving drug fund concept in CSIX may provide the basis for more sustainability in the future.

K2. Attach a list of all members of the final evaluation team and indicate institutional affiliation.

See attached.

APPENDIX G USAID HEALTH AND CHILD SURVIVAL PROJECT QUESTIONNAIRE

1993
USAID Health and Child Survival Project Questionnaire

with AIDS/HIV Activities Reporting Schedule

•• **PVOs** ••

Pages

Country MALAWI

Project Title FY 90 CHILD SURVIVAL GRANT TO ADRA

Project Number 938 ADRA . 01

Name(s) of person(s) responding to questionnaire: Joyce A.Cook

Title(s): Manager Date: 18 October 93

USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY93

Where available, information for questions 1 through 7 has been supplied. Please carefully check the supplied information for accuracy and make any corrections necessary. Where questions are left blank, please supply the requested information. If the Project Number is incorrect, or if the project is new, please write the correct number here and in the spaces provided at the bottom of each page of the questionnaire.

PROJECT IDENTIFICATION

1. Project Number: 938 ADRA.01 2. Subproject Number: _____
3. Country: MALAWI
4. a. Project Title: FY 90 CHILD SURVIVAL GRANT TO ADRA
   b. Subproject Title: _____

CHI USE ONLY
ID: 01.90
Number: 690133
Region: AF
Emphas: Y

5. a. Beginning FY: 1990 (Fiscal Year) b. Beginning FY of Subproject (if appropriate): _____ (Fiscal Year)
6. a. Project Assistance Completion Date (PACD): 08/31/93 (MM/DD/YY)
   b. Termination Date of Subproject (if appropriate): _____ (MM DD YY)
7. Current Status (CIRCLE ONE ANSWER)
   1 - New, no activity yet 2 - Ongoing 3 - Discontinued 4 - Completed

PARTICIPATING AGENCIES

8. For each contract or grant, please provide the **complete** name of the contractor or grantee, the subcontractors working on the project, the host country counterpart(s) and the organization(s) responsible for implementation. Assign a type to each agency named as per the codes indicated below. Use additional sheets if necessary.

		Organization Type
a. Prime Contractor/Grantee or Partner in Cooperative Agreement	Adventist Development and Relief Agency	1
b. Subcontractors		
c. Host Country Counterpart(s)	MOH; Mo Community Service	5
	~~Trinity Hosp; IEE; World Vision~~	~~7~~
d. Organization(s) with major implementing responsibility	Malawian Union of Seventh-day Adventists	7
	MOH	1

Codes for Organization Type (PLACE THE NUMBER CORRESPONDING TO THE CODE IN THE SPACES ABOVE)

1 - Private Voluntary Organizations (U.S.)
2 - Private Voluntary Organizations (Local)
3 - Universities (all countries)
4 - Government (U.S.)
5 - Government (Host Country)
6 - Other Non-profit Organization (U.S.)
7 - Other Non-profit Organization (host and other countries)
8 - Multilateral Agencies
9 - For-profit Firms (all countries)
10 - Other _____ (Please Specify)

e. Provide the name and mailing address of the person or office that should receive relevant technical information from USAID. (PLEASE PRINT CLEARLY)

Name: Dr. Joyce A. Cook
Mailing Address: ADRA
P.O. Box 951
Blantyre, Malawi

9. Percentage Attributions to Program Functions

This question should be answered in two steps. First complete Column A, and then complete Column B.

Step 1 - In **Column A**, write the percent of the Life-of-Project budget (USAID funding) that is attributable to each of the program functions listed. For further explanation, and definitions for each category, please refer to the instruction guide. The percentages in Column A should sum to 100%.

Step 2 - In **Column B**, write the percent of the entry in Column A devoted to Child Survival. In general, diarrheal disease/ORT, immunization, breastfeeding, growth monitoring and weaning foods, and Vitamin A are considered to be 100% Child Survival. In special cases, this may not be true and a percentage other than 100% may be entered in Column B.

PLEASE REVIEW THE EXAMPLE BELOW BEFORE COMPLETING THE TABLE

EXAMPLE

	Column A Total Percent Attribution	Column B Percent for Child Survival	Complete Schedule 1 and...
a. Diarrheal Disease/Oral Rehydration..(HEDD)	40%	100%	▸ Schedule 2
-	-	-	-
-	-	-	-
j. Water and Sanitation for Health ..... (HEWH)	60%	20%	▸ Schedule 7
-	-	-	-
-	-	-	-
TOTAL, All Functions	**100%**		

This means that 20% of the water and sanitation component of the project is attributed to child survival.

9. Percentage Attributions of Fiscal Year 1993 Funds to Program Functions - Continued (See instruction guide for definitions)

	Column A Total Percent Attribution	Column B Percent for Child Survival	Complete Schedule 1 and...
a. Diarrheal Disease/Oral Rehydration..(HEDD)	20	100	▸ Schedule 2
b. Immunization/Vaccination ..... (HEIM)	20	100	▸ Schedule 3
c. Breastfeeding ..... (NUBF)	5	100	▸ Schedule 4
d. Growth Monitoring/Weaning Foods (NUGM)	10	100	▸ Schedule 4
e. Vitamin A ..... (NUVA)	15	100	▸ Schedule 4
f. Women's Health ..... (HEMH)	5	20	▸ Schedule 7
g. Women's Nutrition (including iron) (NUWO)	5	50	▸ Schedule 4
h. Child Spacing/High Risk Births ..... (HECS)	5	80	▸ Schedule 5
i. HIV/AIDS ..... (HEHA)	0		▸ Schedule 6
j. Water and Sanitation for Health ..... (HEWH)	10	10	▸ Schedule 7
k. Acute Respiratory Infections ..... (HERI)	0		▸ Schedule 7
l. Malaria ..... (HEMA)	5	10	▸ Schedule 7
m. Health Care Finance ..... (HEFI)	0		▸ Schedule 7
n. Prosthetics/Medical Rehabilitation .... (HEPR)	0		▸ Schedule 7
o. Orphans/Displaced Children ..... (ORDC)	0		▸ Schedule 7
TOTAL, All Functions	**100%**		

FUNDING INFORMATION

10. What is the total USAID authorized **LIFE-OF-PROJECT** funding for this project (authorized dollar funds from ALL USAID funding accounts)? $ 371,494

11. Commodities

During FY93, were project funds committed to the purchase of any of the following? (PLEASE CIRCLE ALL THAT APPLY.)

a. ORS packets
b. vaccines
c. iron supplements
d. vitamin A
(e.) essential drugs
f. food supplements
g. weighing scales/growth charts
h. contraceptives
i. cold chain equipment
j. laboratory equipment
k. medical equipment
(l.) educational materials
m. audio-visual equipment
n. construction materials for water/sanitation and other activities
o. prosthetics
p. other (please specify) _____

12. What type(s) of initiatives to stimulate or support **the local private sector** are a part of this project? (CIRCLE ALL THAT APPLY.)

(1) - Assistance to privatize public health programs or services
(2) - Training of private sector health care providers
(3) - Involvement of for-profit businesses in project activities
4 - Other (please specify) _____

13. Training Activities

a. Please indicate which of the following groups participated in a course, workshop or training program under the project during FY93: (CIRCLE ALL THAT APPLY.) If available, also provide the number of persons trained.

	Numbers Trained
1 - Physicians	
2 - Nurses	10
3 - Community Health Workers	475
4 - Traditional Healers	25
5 - School Teachers	15
6 - Community Leaders	1200
7 - Mothers	7000
8 - Others (please specify)_____	

b. If training was a significant component of project activities during FY93, please include a brief description of training activities and accomplishments in the space below.

14. Research Activity

Estimate the percent of **Life-of-Project** funds available to this project for research activities related to health and child survival ——————→ 10 % IF 0% SKIP TO ITEM 15

For projects with research percentages > 0%, please provide the following information:

a. **Which program functions** does this research address? (PLEASE CIRCLE ALL THAT APPLY)

1 - ORT/Diarrheal Disease
2 - Immunization/Vaccination
3 - Breastfeeding
4 - Growth Monitoring
5 - Targeted Feeding and Weaning Foods
6 - Vitamin A
7 - Women's Health/Nutrition
8 - Other Nutrition
9 - Child Spacing/High Risk Births
10 - HIV/AIDS
11 - Water and Sanitation
12 - Acute Respiratory Infection
13 - Malaria
14 - Other Vector Borne Disease Control
15 - Health Care Financing
(16) - Health Systems Development
17 - Other (please specify)_____

b. **What types of research** are being funded? (CIRCLE ALL THAT APPLY)

1 - Biomedical
2 - Vaccine Development
3 - Epidemiologic
4 - Behavior/Communications
5 - Policy/Economic/Development
6 - Demographic Data Collection
7 - Operational Research

c. If this project has previously reported research titles, a summary list will be attached on the next page. Please review and update this list with current information.

d. If this is a new project or if there is additional research to report, please provide descriptive titles, years of the research, and the name, affiliation and address of the primary researcher. Also, please specify the program function to which the research is related, and the type of research. Program function codes 1-17 are listed in question 14a and research type codes 1-7 in 14b. (Use additional sheets if necessary.)

Title:_____

_____

Year: BEG:_____ END:_____

Program Function Codes ____ ____ ____ Type Code ____

Name_____

Institution_____

Address_____

Project: 938ADRA/01

FY 90 CHILD SURVIVAL GRANT TO ADRA

Title: VOLUNTEERISM IN COMMUNITY HEALTH

Year: BEG: 1992 END: 1992

Program Function Codes: 18 Type Code: 04

Name: P. COURTRIGHT, PH.D.

Institution: INTERNATIONAL EYE FOUNDATION

Address: P.O. BOX 2273

BLANTYRE, MALAWI

HIGHLIGHTS

15. **Given the diligent reporting efforts of PVOs in the past, information to describe project activities is readily available. The USAID Health and Child Survival Project Questionnaires, PVO Annual Reports and other routine reporting provide valuable descriptive information which is regularly used in Congressional reporting and other USAID documents. Please take a moment here to provide us lessons learned, success stories, or other highlights of your project's activities during the reporting year.**

Village Health Volunteers (VHC)

Based on the anecdotal evidence gathered by the evaluation team in interviews with VHCs, HSAs and others, most of the VHVs are enthusiastic about the work. They say that it has helped them to understand better sanitary and health parcticers, including the importance of latrines and how to manage diarrha, cholera and malaria. One woman said that she learned how to utilize readily available foods to provide good nourishment to her children; one man said that he used to go the the hospital for every illness but now knew how to manage] some health problems at home.

The volunteers are happy to be able to help their communities and to provide mothers with the knowledge of good breastfeeding, nutrition and oral rehydration practices. They maintain supplies of ORS in their homes and are called upon when ORS is needed. THe communities appreciate the volunteers and particularly having access to ORS in the vollage. It is interesting to note that there are not many other, if any, community development volunteers in project villages which could account for some of the apparent success of the health volunteers.

Volunteers usually work part of one of two days per week and are "oncall" at all times. They visit high risk families in their homes, meet with groups in the community and assist at the under five clinics. Between August 1992 and July 1993 volunteers reported visiting an average of 67 % of high risk families at least once per month; statistics for the last six months only indicate over 80 % of high risk families were visited monthly.

Since the referendum, there appears to be a new attitude toward volunteerism. The new parties have campaigned on promises of a brighter econimic future whicc has encouraged people to believe that they can be paid for their work. The MSF volunteers went on strike recently. It is currently the policy of both governmental and nongovernment organizations in Malawi not to compensate volunteers. ADRA has participated in an IEF-sponsored study of VHVs in Malawi. It is hoped that the results will provide some helpful insights to ADRA and perhaps for the entire country.

16. **Because photographs can often communicate important concepts to busy decision makers much more quickly than words, can you include photographs to supplement the above text? (If yes, please include credit/caption information, including the location and year of the photo on a separate sheet and place picture, slide, or negative in an envelope.) Do not write on photos.**

Photographs included? **1 - Yes** **2 - No**

Schedule 1 DEMOGRAPHIC CHARACTERISTICS

1 - 1 What is the **geographic area** in which this project is delivering and/or promoting health or child survival services? (CIRCLE ONE ANSWER)

1 - The entire country

(2) A geographic area smaller than the entire country

} COMPLETE ITEMS 1-2 THROUGH 1-5

3 - None. The project does not deliver or promote services.

9 - Don't know

} CONTINUE DIRECTLY TO NEXT SCHEDULE

1 - 2 In this space, state the **geographic location** of the project so that areas with project activities may be located on a national map.

1 - 3 What is the **total population** of the area in which the project is operating? 216,066

1 - 4 Potential Beneficiary Population

Provide the **number of potential beneficiaries** in each age group:

a. 0 - 11 months	5200
b. 12 - 59 months	9000
c. Women 15 - 44 years	22000
d. Other (please specify) Village Health Committees (VHCs)	1500

Definition: Potential beneficiaries refers to the number eligible to receive services for a given age group. This includes only potential recipients of direct services (i.e., immunizations or family planning).

e. In this space, briefly describe any other target groups on which project services/activities are focused.

VHC members are lenders in health promotion at the village level.

1 - 5 Is the population served living primarily in an **urban or rural** area? (CIRCLE ONE)

1 - Primarily urban

3 - Mixed

(2) Primarily rural

4 - Don't know

Schedule 2 DIARRHEAL DISEASE CONTROL

FOCUS AND ACTIVITIES

2 - 1 For the Diarrheal Disease Control component of this project, please indicate if the project sponsored, promoted or participated in each activity during **fiscal year 1993.**

	Project activity during FY93? Yes	No
a. Community-level education to:		
1. Raise awareness of the dangers of dehydration	(Y)	N
2. Enable mothers to recognize when prompt medical treatment is necessary	(Y)	N
3. Encourage proper personal hygiene/food handling practices	(Y)	N
b. Case management of diarrhea through:		
1. Promotion of home-based practices:		
- recommended home fluids	(Y)	N
- sugar/salt solutions	Y	(N)
- continued breastfeeding during diarrhea	(Y)	N
- other appropriate feeding during and after diarrhea	(Y)	N
2. Promotion/Distribution of ORS packets	(Y)	N
3. Strengthening referral mechanisms for severe cases	(Y)	N
c. Upgrading of clinical services including the rational use of drugs	(Y)	N
d. Training		
1. Training of health care professionals	Y	(N)
2. Training of outreach workers (TBAs, traditional healers, community health workers)	(Y)	N
e. Other activities		
1. Improved disease surveillance systems	(Y)	N
2. Improved water or sanitation	(Y)	N
3. Other (specify) _____	Y	(N)

ADDITIONAL BACKGROUND INFORMATION

2 - 2 Please provide any other background information which would enable us to better understand the unique nature of the project's diarrheal disease component including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary).

ATTACHED

CHILD SURVIVAL INDICATORS

2 - 3 What is the ORT use rate in the project area?

a. ORT use rate ——— ▸	85 %		
b. Date(mo/yr) data was collected ——— ▸	93		
c. Source of the data used to make the estimate	*DC	BG	DK

The definition of ORT use rate is "the proportion of all cases of diarrhea in children under five treated with ORS and/or recommended home fluid. In surveys, this rate is generally estimated as the proportion of diarrhea episodes occurring in the last two weeks treated with ORT."

average of monthly totals collected by staff

d. If a data collection system was used, please describe it. Please give the name of the **agency** responsible for the system (MOH, WHO, UNICEF), its scope (national or project **area** specific), its **permanence** (special study or ongoing monitoring system), the **methodology** used (sample survey, clinic-based statistics, village-based statistics, and the **computational procedure** (weighting in a sample, weighting of data from clinics or villages, etc.).

* Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

ADDITIONAL BACK-GROUND INFORMATION ON CDD

KALAGALA/ZIROBWE SUB-COUNTIES

The Project has decided to put more emphasis and encourage use of Cereal Based Therapy than sugar, salt solutions (sss) or even the distribution sachets.

During our Education visits, it was discovered that about 90% of the mothers when asked how to prepare sugar, salt solutions, were unable to give right measurements of sugar spoons or salt. Others confused 8 spoons for salt to one of sugar, others 4 spoons of sugar to two of salt, others confused over the amount of water.

Another point is that sugar is very expensive for the ordinarly rural people here. It ranges from 900 to 1200 Ug. shillings per Killogram which is not very easy for them to spend because this child is sick.

Everyone in the community has welcomed the use of Cereal Based Therapy because it is easy to prepare, very cheap and most times readly available. Not only that, but even super in managing Diarrhoea.

The stapple food in this area is Matooke (Plantain) and other foods commonly used are Cassava, and Sweet potatoes. The fact being that these are the commonest types of foods in the community, the project has gone ahead and encouraged them to use these Startch Based foods in treating diarrhoeas.

We have asked them to cut the Matooke, Cassava, or Potatoes in small pieces to fill half of the mug, then pour it in a sourcepan, fill the sauce pan with one litre of water, mark the line, add ½ litre of water. Put on fire and boil until when the water dries to the marked line, add one leveled tea spoon of salt, mix well and leave it to cool then give the child as much as he can take.

Mr. Kuuku Wilson is the Chairman RC I Kyetume in the Sub-Parish of Vumba B. Kalagala Sub-county which is one of our Project Area. Wilson is a father to a young daughter who was admitted to Mulago, a National refferal Hospital for several weeks due to

.../2

diarrhoea. In Mulago the child was treated with all the antibiotics and the anti-parasitics available but as weeks past the child became weaker and weaker until when every one lost hope. Wilson was advised to take his daughter back home, since it would be cheaper for him to transport the family members before the child is dead. Among the community members who came to see the dying child, was Nakayenga, one of our Village Health Promoters. When she learnt that the killing disease was diarrhoea, she also wanted to give a try. She asked the parents to stop giving any other food or drink, but mashed Sweet bananas and Cereal Based Therapy from Maize porridge. Within a week, the child had come back to life.

Schedule 3 IMMUNIZATION

FOCUS AND ACTIVITIES

3 - 1 For the Immunization component of this project, please indicate if the project sponsored, promoted or participated in each activity during fiscal year 1993.

	Project activity during FY93? Yes	No
a. EPI promotion and services		
1. Activities directed to promote use of services	(Y)	N
2. Delivery of vaccination services through:		
- Mass campaigns	(Y)	N
- Fixed centers	(Y)	N
- Mobile vaccination teams	(Y)	N
- Outreach and follow-up services	(Y)	N
3. Vaccination of women with tetanus toxoid	(Y)	N
4. Vaccination against measles	(Y)	N
b. Training		
1. Training of health care professionals	(Y)	N
2. Training of outreach workers (TBAs, traditional healers, community health workers)	(Y)	N
c. Other activities		
1. Improved surveillance for vaccine preventable diseases	(Y)	N
2. Equipment and training for improved cold chain	(Y)	N
3. Other (specify) _____	Y	N

ADDITIONAL BACKGROUND INFORMATION

3 - 2 Please provide any other background information which would enable us to better understand the unique nature of the project's immunization component, including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. **Due to the newly announced measles initiative, we are particularly interested in hearing about any measles activity undertaken through this project.** (Attach additional sheets if necessary).

CHILD SURVIVAL INDICATORS

3 - 3 What is the **vaccination coverage rate** (see instruction guide for information on definitions) in the project area?

	BCG	DPT3	Polio3	Measles	Tetanus for Women
Percent vaccinated (children by 12 months, or women)	62	71	63	45	5
Date (month/year) data was collected	'89	'89	'89	'89	'89
Source of information (CIRCLE ONE)	*DC BG DK	*DC BG DK	*DC BG DK	*DC BG DK	*DC BG DK

* Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

d. If a data collection system was used, please describe it. Please give the name of the **agency** responsible for the system (MOH, WHO, UNICEF), its scope (national or project **area** specific), its **permanence** (special study or ongoing monitoring system), the **methodology** used (sample survey, clinic-based statistics, village-based statistic), and the **computational procedure** (weighting in a sample, weighting of data from clinics or villages, etc.).

Mott, Nsanje District 1989 annual report

Schedule 4 NUTRITION

FOCUS AND ACTIVITIES

4 - 1 For the Nutrition component of this project, please indicate if the project sponsored, promoted or participated in each activity during **fiscal year 1993.**

	Project activity during FY93? Yes	No
a. Breastfeeding		
1. Exclusive breastfeeding for first 4 - 6 months	(Y)	N
2. Initiation of breastfeeding within 1 hour after birth	(Y)	N
3. Increased duration of breastfeeding	(Y)	N
4. Continued breastfeeding during diarrhea	(Y)	N
5. Development of support groups or mechanisms for home visitation to counsel and assist mothers	(Y)	N
6. Revised policy for hospitals and maternity centers	Y	(N)
7. Policy dialogue in support of a favorable environment for breastfeeding	Y	(N)
b. Weaning and child feeding		
1. Community education for proper child feeding practices	(Y)	N
2. Emphasis on correct feeding during and after diarrhea and other infections	(Y)	N
3. Development and promotion of locally acceptable weaning foods	(Y)	N
c. Growth monitoring		
1. Use of growth monitoring as a tool for counseling mothers	(Y)	N
2. Use of growth monitoring as a means of nutritional status surveillance	(Y)	N
3. Strengthening of health worker skills in growth monitoring and counseling	(Y)	N
d. Vitamin A and other micronutrient deficiencies		
1. Assessment of levels of vitamin A deficiency	(Y)	N
2. Case detection and treatment of vitamin A deficiency	(Y)	N
3. Vitamin A supplements for children and/or post partum women	(Y)	N
4. Inclusion of vitamin A in treatment of measles	(Y)	N
5. Communication activities to promote increased dietary intakes	(Y)	N
6. Food fortification	(Y)	N
7. Home and community gardens	(Y)	N
8. Iron and folate supplements for women of reproductive age	(Y)	(N)
e. Training		
1. Training of health care professionals	(Y)	N
2. Training of outreach workers (TBAs, traditional healers, community health workers)	(Y)	N
f. Other_____	Y	N

SUPPLEMENTAL FEEDING TARGET GROUPS

4 - 2 If the project sponsored **supplementary feeding** during FY93, which groups were targeted? (CIRCLE ALL THAT APPLY)

1 - All ages
(2) - Children under 12 months
(3) - Children 12 - 23 months
(4) - Children 24 - 35 months
5 - Children 36 - 60 months
(6) - Pregnant or lactating women
7 - Other women
8 - Other_____
9 - None
10 - Don't know

ADDITIONAL BACKGROUND INFORMATION

4 - 3 **Please provide any other background information which would enable us to better understand the unique nature of the project's nutrition component including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary).**

In collaboration with the IEF, the CS project became involved in vitamin A activities; education on vitamin A-rich foods and capsule distribution. Training of HSAs and volunteers began in early 1992. There were three capsule distributions to children between 3 months and 6 years of age and breastfeeding mothers of children under 3 months; June and December 1992 and June 1993. Approximately 8,500 capsules were distributed in the first distribution, 13,800 in the second and 15,700 in the third. The second distribution reached approximately 87% of the target population and the third, which included a larger area, reached approximately 79% of the target popu ti

CHILD SURVIVAL INDICATORS

4 - 4 a. **What is the rate of malnutrition** in the target group served by the project?

Definition: Rate of malnutrition is "the proportion of children whose weight-for-age is below two standard deviations of the norm established by the National Center for Health Statistics (the norm endorsed by the World Health Organization)."

	Group 1	Group 2	Group 3	Group 4
Target group →	Children 0-11 months	Children 12-23 months	Other 6-59 Specify months	Other Specify_____
Estimate rate of malnutrition →			3.6 %	
Date (month/year) of estimate →			10/92	
Source of information (CIRCLE ONE)	*DC BG DK	*DC BG DK	(*DC) BG DK	*DC BG DK

* Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

b. **If a data collection system was used, please describe it. Please give the name of the agency responsible for the system (MOH, WHO, UNICEF), its scope (national or project area specific), its permanence (special study or ongoing monitoring system), the methodology used (sample survey, clinic-based statistics, village-based statistic), and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc.).**

MSF/Holland, Nsanje District, ongoing monitoring during drought, sample survey

Schedule 5 HIGH RISK BIRTHS

FOCUS AND ACTIVITIES

5 - 1 For the High Risk Birth component of this project, please indicate if the project sponsored, promoted or participated in each activity during fiscal year 1993.

	Project activity during FY93? Yes	No
a. Community education to:		
1. Raise awareness of the importance of preventing high risk births	(Y)	N
2. Promote modern contraceptive methods for child spacing	(Y)	N
3. Promote breastfeeding as a method for child spacing	(Y)	N
4. Promote other natural family planning methods	(Y)	N
b. Strengthening of service delivery by:		
1. Developing a system to identify and refer high risk women for family planning services	(Y)	N
2. Training medical staff in clinical and counseling skills for child spacing methods	(Y)	N
c. Activities specifically directed at one or more of the following high risk groups:		
1. Women under age 18	(Y)	N
2. Women age 35 or older	(Y)	N
3. Women who have given birth within the previous 24 months	(Y)	N
4. Women with 4 or more children	(Y)	N
d. Training		
1. Training of health care professionals	(Y)	N
2. Training of outreach workers (TBAs, traditional healers, community health workers)	(Y)	N
e. Other _____ (please specify)	Y	N

ADDITIONAL BACKGROUND INFORMATION

5 - 2 Please provide any other background information which would enable us to better understand the unique nature of the project's high risk birth component including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary).

CONTRACEPTIVE PREVALENCE RATE

5 - 3 What is the Contraceptive Prevalence Rate in the project area?

a. Contraceptive prevalence rate in area	7%
b. Date(mo/yr) data was collected	6/93
c. Source of the data used to make the estimate	(DC) BG DK

The definition of Contraceptive Prevalence Rate is "the proportion of women aged 15 - 44 years, or in some countries, 15 - 49 years, in union or married, currently using a modern method of contraception."

*Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

d. If a data collection system was used, please describe it. Please give the name of the agency responsible for the system (MOH, WHO, UNICEF), its scope (national or project area specific), its permanence (special study or ongoing monitoring system), the methodology used (sample survey, clinic-based statistics, village-based statistic), and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc.).

ADRA CS 6, Nsanje district, final cluster survey

Schedule 6 HIV/AIDS ACTIVITIES

6 - 1 Does this project provide funding or otherwise support activities in HIV/AIDS prevention? ___ YES ✓ NO

If your answer is YES, please use the table below to define the scope of the HIV/AIDS activities supported under this project. Provide your data in columns B through G on the basis of the Activity Categories identified in Column A.

Column B Attribute to each specific Activity Category the corresponding percent from the total FY93 obligations to HIV/AIDs programs as listed in Question 9j of the main schedule. Column B should add to 100%.

Column C Estimate the percent of resources supporting research for each activity reported in Column A.

Column D From page 1, please list the organizations which were involved in HIV/AIDS activities supported under this project. Abbreviate if necessary.

Column E Use the numbers corresponding to Target Population descriptions as appropriate for each activity.

Column F Indicate by Y or N (Yes or No) whether activities listed in Column A are community-based with target community involvement in the design, implementation, and/or evaluation of the activities.

Column G Please cite the number of individuals reached by prevention efforts in each activity area. Use your best guess if no data has been collected for this variable.

A Activity Category	B % of AIDS Attribution	C % Research	D Organizations Supported	E Target Population	F Community-based	G Nos. Reached FY93
BER						
CSP						
CPD						
PNR						
STD						
PDM						
OA1						
	100%					

ACTIVITY CATEGORY CODES:

BER - Behavioral Research
CSP - Condom Supply
CPD - Condom Protection and Distribution
PNR - Partner Number Reduction
STD - STD Management and Control
PDM - Policy Dialogue/Modeling
OA1 - Other (please specify)_____

TARGET POPULATION CODES:

1 - General Public
2 - Community Leaders
3 - Children (0-8 years)
4 - Youth (9-14 years)
5 - Female Sex Workers
6 - Male Sex Workers
7 - Other Women at Risk
8 - Other Men at Risk
9 - IV Drug Users
10 - Health Service Providers
11 - STD Patients
12 - Other (please specify)_____

6 - 2 The AIDS Division of R&D/Health needs descriptive information on all Mission sponsored HIV/AIDS programs for the Agency's Report to Congress. We would encourage you to attach to this questionnaire a brief but comprehensive description on the HIV/AIDS programs your project sponsors. Providing this information now would eliminate the need for further requests for such summaries.

Schedule 7 OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES

This schedule is designed to record information about health and child survival interventions other than those identified in schedules 2 through 6

IDENTIFICATION OF OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES

7 - 1 What type(s) of "other" health and child survival interventions received funding or other support through this project? (CIRCLE ALL THAT APPLY)

1 - Acute Respiratory Infection (answer 7 - 3)
2 - Maternal Health (answer 7 - 4)
3 - Health Care Financing (answer 7 - 5)
(4) Malaria (answer 7 - 6)
(5) Water and Sanitation
(6) Elderly/Adult Health
7 - Prosthetics
8 - Tuberculosis
9 - Other (please specify)_____

7 - 2 Please provide any other background information which would enable us to better understand the unique nature of the project's other health and child survival activities, including those not identified above, any specific lessons learned, any special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary). Unanticipated Constraints

The most serious draught in sixty years affected the project regfion with severe food shortages from mid 1992 through the first trimester of 1993. ADRA participated on the Draught Relief Coordinating Committee. It was decided that ADRA would continue regular project activities while MSF carried out nutrition surveys and the Red Cross was responsible for food distribution. Although the program did continue it was hampered in many ways; Volunteers were not able to devote as much time to project activities because they had to find food for their families; some of the villagers moved temporarily to areas close to the river where they could cultivate which appears to have resulted in (ov

FOCUS AND ACTIVITIES

For the interventions specified, please indicate which of the following activities are major elements of the **life-of-project** implementation strategy (in terms of project funds and human resources committed for this intervention); and 2) whether or not the project sponsored, promoted or participated in each activity during fiscal year 1993.

PLEASE ANSWER 7 - 3 ONLY IF YOU CIRCLED "1 - Acute Respiratory Infection" IN RESPONSE TO 7 - 1.

7 - 3 Acute Respiratory Infection Strategies	Project activity during FY93? Yes	No
a. Community-level education to:		
1. Raise awareness of the dangers of acute respiratory infection	Y	N
2. Enable mothers to recognize when prompt medical treatment is necessary	Y	N
b. Case management of respiratory infection:		
1. Training of clinical staff in case management and treatment	Y	N
2. Training of community workers in case management and referral	Y	N
3. Provision of equipment and timers for diagnosis	Y	N
4. Provision of appropriate drugs for pneumonia treatment _____ (specify drugs)	Y	N
5. Education of health staff and pharmacists to encourage rational use of antibiotics	Y	N
c. Other _____ (please specify)	Y	N

7-2 (continued)

continued dislocation of some village populations; staff members spent more time collecting water for their own needs; the garden component lapsed in many places; diarrhea, including bloody diarrhea and cholera were prevalent due to the poor quality of water; many people did not have enough to eat; MOH resources were diverted to cholera camps resulting in a breakdown of the MOH distribution system and shortages of ORS and other medications throughout the region.

ANSWER ONLY IF YOU CIRCLED "2 - Maternal Health" IN RESPONSE TO 7 - 1.

7 - 4 Maternal Health Strategies	Project activity during FY93? Yes	No
1. Communication activities to increase women's healthy practices during pregnancy, and use of prenatal care and maternity services	Y	N
2. Training and equipment for traditional birth attendants (TBAs), midwives, and other health workers:		
- training in screening and referral of high-risk pregnancies	Y	N
- training in life-saving delivery skills	Y	N
- provision of safe delivery kits	Y	N
3. Strengthening referral systems between TBAs, health centers, and hospitals	Y	N
4. Integration of maternity care with family planning	Y	N
5. Treatment of infections, especially sexually-transmitted diseases	Y	N

ANSWER ONLY IF YOU CIRCLED "3 - Health Care Financing" IN RESPONSE TO 7 - 1.

7 - 5 Health Care Financing Strategies	Project activity during FY93? Yes	No
1. Fees for health services	Y	N
2. Income generation to support project activities _____ (please specify)	Y	N
3. Other _____ (please specify)	Y	N

ANSWER ONLY IF YOU CIRCLED "4 - Malaria" IN RESPONSE TO 7 - 1.

7 - 6 Malaria Strategies	Project activity during FY93? Yes	No
a. Prevention		
1. Public education to:		
- increase awareness of malaria and methods of prevention	(Y)	N
- enable mothers to recognize when and where to seek treatment	(Y)	N
2. Prevention of disease transmission through:		
- personal protection methods (impregnated bednets, etc.)	(Y)	N
- vector control (against adult mosquitos, against larvae, etc.)	Y	(N)
- environmental management	Y	(N)
b. Case management of malaria		
1. Standardization of protocols for case management	(Y)	N
2. Training of community workers in case management and referral	(Y)	N
3. Training of clinical staff in case management and treatment	(Y)	N
4. Provision of antimalarial drugs	(Y)	N
c. Other _____ (please specify)	Y	(N)

1993
USAID Health and Child Survival Project Questionnaire

with AIDS/HIV Activities Reporting Schedule

-- **PVOs** --

Country MALAWI

Project Title FY 90 VITAMIN A GRANT TO ADRA

Project Number 938 ADRA.04

Name(s) of person(s) responding to questionnaire: _____

Title(s): _____ Date: _____

USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY93

Where available, information for questions 1 through 7 has been supplied. Please carefully check the supplied information for accuracy and make any corrections necessary. Where questions are left blank, please supply the requested information. If the Project Number is incorrect, or if the project is new, please write the correct number here and in the spaces provided at the bottom of each page of the questionnaire.

PROJECT IDENTIFICATION

1. Project Number: 938 ADRA 2. Subproject Number: 04
3. Country: MALAWI
4. a. Project Title: FY 90 VITAMIN A GRANT TO ADRA
   b. Subproject Title: _____

CIHI USE ONLY
I.D.: 04,90
Number: E90253
Region: AF
Emphas: Y

5. a. Beginning FY: 1990 (Fiscal Year) b. Beginning FY of Subproject (if appropriate): _____ (Fiscal Year)
6. a. Project Assistance Completion Date (PACD): 08/31/93 (MM/DD/YY)
   b. Termination Date of Subproject (if appropriate): _____ (MM DD YY)
7. Current Status (CIRCLE ONE ANSWER)
   1 - New, no activity yet 2 - Ongoing 3 - Discontinued 4 - Completed

PARTICIPATING AGENCIES

8. For each contract or grant, please provide the **complete** name of the contractor or grantee, the subcontractors working on the project, the host country counterpart(s) and the organization(s) responsible for implementation. Assign a type to each agency named as per the codes indicated below. Use additional sheets if necessary.

		Organization Type
a. Prime Contractor/Grantee or Partner in Cooperative Agreement		
b. Subcontractors		
c. Host Country Counterpart(s)		
d. Organization(s) with major implementing responsibility		

Codes for Organization Type (PLACE THE NUMBER CORRESPONDING TO THE CODE IN THE SPACES ABOVE)

1 - Private Voluntary Organizations (U.S.)
2 - Private Voluntary Organizations (Local)
3 - Universities (all countries)
4 - Government (U.S.)
5 - Government (Host Country)
6 - Other Non-profit Organization (U.S.)
7 - Other Non-profit Organization (host and other countries)
8 - Multilateral Agencies
9 - For-profit Firms (all countries)
10 - Other _____ (Please Specify)

e. Provide the name and mailing address of the person or office that should receive relevant technical information from USAID. (PLEASE PRINT CLEARLY)

Name: _____
Mailing Address: _____

9. Percentage Attributions to Program Functions

This question should be answered in two steps. First complete Column A, and then complete Column B.

Step 1 - In **Column A**, write the percent of the Life-of-Project budget (USAID funding) that is attributable to each of the program functions listed. For further explanation, and definitions for each category, please refer to the instruction guide. The percentages in Column A should sum to 100%.

Step 2 - In **Column B**, write the percent of the entry in Column A devoted to Child Survival. In general, diarrheal disease/ORT, immunization, breastfeeding, growth monitoring and weaning foods, and Vitamin A are considered to be 100% Child Survival. In special cases, this may not be true and a percentage other than 100% may be entered in Column B.

PLEASE REVIEW THE EXAMPLE BELOW BEFORE COMPLETING THE TABLE

EXAMPLE

	Column A Total Percent Attribution	Column B Percent for Child Survival	Complete Schedule 1 and...
a. Diarrheal Disease/Oral Rehydration..(HEDD)	40%	100%	▸ Schedule 2
-	-	-	-
-	-	-	-
j. Water and Sanitation for Health ..... (HEWH)	60%	20%	▸ Schedule 7
-	-	-	-
-	-	-	-
TOTAL, All Functions	**100%**		

This means that 20% of the water and sanitation component of the project is attributed to child survival.

9. Percentage Attributions of Fiscal Year 1993 Funds to Program Functions - Continued (See instruction guide for definitions)

	Column A Total Percent Attribution	Column B Percent for Child Survival	Complete Schedule 1 and...
a. Diarrheal Disease/Oral Rehydration..(HEDD)	20	100	▪ Schedule 2
b. Immunization/Vaccination ..... (HEIM)	20	100	▸ Schedule 3
c. Breastfeeding ..... (NUBF)	5	100	▸ Schedule 4
d. Growth Monitoring/Weaning Foods (NUGM)	10	100	▸ Schedule 4
e. Vitamin A ..... (NUVA)	15	100	▸ Schedule 4
f. Women's Health ..... (HEMH)	5	20	▪ Schedule 7
g. Women's Nutrition (including iron) (NUWO)	5	50	▪ Schedule 4
h. Child Spacing/High Risk Births ..... (HECS)	5	80	▪ Schedule 5
i. HIV/AIDS ..... (HEHA)	0		▸ Schedule 6
j. Water and Sanitation for Health ..... (HEWH)	10	10	▪ Schedule 7
k. Acute Respiratory Infections ..... (HERI)	0		▸ Schedule 7
l. Malaria ..... (HEMA)	5	10	▸ Schedule 7
m. Health Care Finance ..... (HEFI)	0		▪ Schedule 7
n. Prosthetics/Medical Rehabilitation .... (HEPR)	0		▪ Schedule 7
o. Orphans/Displaced Children ..... (ORDC)	0		▸ Schedule 7
TOTAL, All Functions	**100%**		

FUNDING INFORMATION

10. What is the total USAID authorized **LIFE-OF-PROJECT** funding for this project (authorized dollar funds from ALL USAID funding accounts)? $ 371,494

11. Commodities

During FY93, were project funds committed to the purchase of any of the following? (PLEASE CIRCLE ALL THAT APPLY.)

a. ORS packets
b. vaccines
c. iron supplements
d. vitamin A
(e) essential drugs
f. food supplements
g. weighing scales/growth charts
h. contraceptives
i. cold chain equipment
j. laboratory equipment
k. medical equipment
(l.) educational materials
m. audio-visual equipment
n. construction materials for water/sanitation and other activities
o. prosthetics
p. other (please specify) _____

12. What type(s) of initiatives to stimulate or support **the local private sector** are a part of this project? (CIRCLE ALL THAT APPLY.)

(1) - Assistance to privatize public health programs or services
(2) - Training of private sector health care providers
(3) - Involvement of for-profit businesses in project activities
4 - Other (please specify) _____

13. Training Activities

a. Please indicate which of the following groups participated in a course, workshop or training program under the project during FY93: (CIRCLE ALL THAT APPLY.) If available, also provide the number of persons trained.

	Numbers Trained
1 - Physicians	
2 - Nurses	10
3 - Community Health Workers	475
4 - Traditional Healers	25
5 - School Teachers	15
6 - Community Leaders	1200
7 - Mothers	7000
8 - Others (please specify)_____	

b. If training was a significant component of project activities during FY93, please include a brief description of training activities and accomplishments in the space below.

14. Research Activity

Estimate the percent of **Life-of-Project** funds available to this project for research activities related to health and child survival ——————→ 10 % IF 0% SKIP TO ITEM 15

For projects with research percentages > 0%, please provide the following information:

a. **Which program functions** does this research address? (PLEASE CIRCLE ALL THAT APPLY)

1 - ORT/Diarrheal Disease
2 - Immunization/Vaccination
3 - Breastfeeding
4 - Growth Monitoring
5 - Targeted Feeding and Weaning Foods
6 - Vitamin A
7 - Women's Health/Nutrition
8 - Other Nutrition
9 - Child Spacing/High Risk Births
10 - HIV/AIDS
11 - Water and Sanitation
12 - Acute Respiratory Infection
13 - Malaria
14 - Other Vector Borne Disease Control
15 - Health Care Financing
(16) - Health Systems Development
17 - Other (please specify)_____

b. **What types of research** are being funded? (CIRCLE ALL THAT APPLY)

1 - Biomedical
2 - Vaccine Development
3 - Epidemiologic
4 - Behavior/Communications
5 - Policy/Economic/Development
6 - Demographic Data Collection
7 - Operational Research

c. If this project has previously reported research titles, a summary list will be attached on the next page. Please review and update this list with current information.

d. If this is a new project or if there is additional research to report, please provide descriptive titles, years of the research, and the name, affiliation and address of the primary researcher. Also, please specify the program function to which the research is related, and the type of research. Program function codes 1-17 are listed in question 14a and research type codes 1-7 in 14b. (Use additional sheets if necessary.)

Title:_____

_____

Year: BEG:_____ END:_____

Program Function Codes ____ ____ ____ Type Code ____

Name_____

Institution_____

Address_____

Project: 938ADRA/04

==========

No Titles For This Project

USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE - FY93

HIGHLIGHTS

15. **Given the diligent reporting efforts of PVOs in the past, information to describe project activities is readily available. The USAID Health and Child Survival Project Questionnaires, PVO Annual Reports and other routine reporting provide valuable descriptive information which is regularly used in Congressional reporting and other USAID documents. Please take a moment here to provide us lessons learned, success stories, or other highlights of your project's activities during the reporting year.**

Village Health Volunteers (VHC)

Based on the anecdotal evidence gathered by the evaluation team in interviews with VHCs, HSAs and others, most of the VHVs are enthusiastic about the work. They say that it has helped them to understand better sanitary and health practicers, including the importance of latrines and how to manage diarrhea, cholera and malaria. One woman said that she learned how to utilize readily available foods to provide good nourishment to her children; one man said that he used to go to the hospital for every illness but now knew how to manage some health problems at home.

The volunteers are happy to be able to help their communities and to provide mothers with the knowledge of good breastfeeding, nutrition and oral rehydration practices. They maintain supplies of ORS in their homes and are colled upon when ORS is needed. The communities appreciate the volunteers and particularly having access to ORS in the village. It is interesting to note that there are not many other, if any, community development volunteers in project villages which could account for some of the apparent success of the health volunteers.

Volunteers usually work part of one or two days per weed and are "oncall" at all times. They visit high risk families in their homes, meet with groups in the community and assist at the under five clinics. Between August 1992 and July 1993 volunteers reported visiting an average of 67% of high risk families at least once per month; statistics for the last six months only indicate over 80% of high risk families were visited monthly.

Since the referendum, there appears to be a new attitude toward volunteerism. The new parties have campaigned on promises of a brighter econimic future which ahs encouraged people to believe that they can be paid for their work. The MSF volunteers went on strike recently. It is currently the policy of both governmental and non-government organizations in Malawi not to compensate volunteers. ADRA has participated in an IEF-sponsored study of VHVs in Malawi. It is hoped that the results will provide some helpful insights to ADRA and perhaps for the entire country.

16. **Because photographs can often communicate important concepts to busy decision makers much more quickly than words, can you include photographs to supplement the above text? (If yes, please include credit/caption information, including the location and year of the photo on a separate sheet and place picture, slide, or negative in an envelope.) Do not write on photos.**

Photographs included? **1 - Yes** (2) **No**

Schedule 1 DEMOGRAPHIC CHARACTERISTICS

1 - 1 What is the **geographic area** in which this project is delivering and/or promoting health or child survival services? (CIRCLE ONE ANSWER)

1 - The entire country
(2) A geographic area smaller than the entire country
} COMPLETE ITEMS 1-2 THROUGH 1-5

3 - None. The project does not deliver or promote services.
9 - Don't know
} CONTINUE DIRECTLY TO NEXT SCHEDULE

1 - 2 In this space, state the **geographic location** of the project so that areas with project activities may be located on a national map.

The project is located in the Nsaje District, in the extreme southern tip of Malawi. The project covers the northern half of the district which was divided into two operational areas, one on the east bank of the Shire River and the other on the west bank as far south as Tengani.

1 - 3 What is the **total population** of the area in which the project is operating? 216,066.[2]

1 - 4 Potential Beneficiary Population

Provide the **number of potential beneficiaries** in each age group:

a. 0 - 11 months	5,200
b. 12 - 59 months	9,000
c. Women 15 - 44 years	22,000
d. Other (please specify) Hillage Health Committees (VHCs)	1,500

Definition: Potential beneficiaries refers to the number eligible to receive services for a given age group. This includes only potential recipients of direct services (i.e., immunizations or family planning).

e. In this space, briefly describe any other target groups on which project services/activities are focused.

VHC members are leaders in health promotion at the village level.

1 - 5 Is the population served living primarily in an **urban or rural area?** (CIRCLE ONE)

1 - Primarily urban
3 - Mixed
(2) Primarily rural
4 - Don't know

Schedule 2 DIARRHEAL DISEASE CONTROL

FOCUS AND ACTIVITIES

2 - 1 For the Diarrheal Disease Control component of this project, please indicate if the project sponsored, promoted or participated in each activity during **fiscal year 1993.**

	Project activity during FY93? Yes	No
a. Community-level education to:		
1. Raise awareness of the dangers of dehydration	(Y)	N
2. Enable mothers to recognize when prompt medical treatment is necessary	(Y)	N
3. Encourage proper personal hygiene/food handling practices	(Y)	N
b. Case management of diarrhea through:		
1. Promotion of home-based practices:		
- recommended home fluids	(Y)	N
- sugar/salt solutions	Y	(N)
- continued breastfeeding during diarrhea	(Y)	N
- other appropriate feeding during and after diarrhea	(Y)	N
2. Promotion/Distribution of ORS packets	(Y)	N
3. Strengthening referral mechanisms for severe cases	(Y)	N
c. Upgrading of clinical services including the rational use of drugs	(Y)	N
d. Training		
1. Training of health care professionals	Y	(N)
2. Training of outreach workers (TBAs, traditional healers, community health workers)	(Y)	N
e. Other activities		
1. Improved disease surveillance systems	(Y)	N
2. Improved water or sanitation	(Y)	N
3. Other (specify) _____	Y	(N)

ADDITIONAL BACKGROUND INFORMATION

2 - 2 Please provide any other background information which would enable us to better understand the unique nature of the project's diarrheal disease component including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary).

ATTACHED

CHILD SURVIVAL INDICATORS

2 - 3 What is the ORT use rate in the project area?

a. ORT use rate ——►	85 %
b. Date(mo/yr) data was collected ——►	1993
c. Source of the data used to make the estimate	(*DC) BG DK

Average of monthly totals collected by staff

The definition of ORT use rate is "the proportion of all cases of diarrhea in children under five treated with ORS and/or recommended home fluid. In surveys, this rate is generally estimated as the proportion of diarrhea episodes occurring in the last two weeks treated with ORT."

* Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

d. If a data collection system was used, please describe it. Please give the name of the **agency** responsible for the system (MOH, WHO, UNICEF), its scope (national or project **area** specific), its **permanence** (special study or ongoing monitoring system), the **methodology** used (sample survey, clinic-based statistics, village-based statistics, and the **computational procedure** (weighting in a sample, weighting of data from clinics or villages, etc.).

ADDITIONAL BACK-GROUND INFORMATION ON CDD

KALAGALA/ZIROBWE SUB-COUNTIES

The Project has decided to put more emphasis and encourage use of Cereal Based Therapy than sugar, salt solutions (sss) or even the distribution sachets.

During our Education visits, it was discovered that about 90% of the mothers when asked how to prepare sugar, salt solutions, were unable to give right measurements of sugar spoons or salt. Others confused 8 spoons for salt to one of sugar, others 4 spoons of sugar to two of salt, others confused over the amount of water.

Another point is that sugar is very expensive for the ordinarly rural people here. It ranges from 900 to 1200 Ug. shillings per Killogram which is not very easy for them to spend because this child is sick.

Everyone in the community has welcomed the use of Cereal Based Therapy because it is easy to prepare, very cheap and most times readly available. Not only that, but even super in managing Diarrhoea.

The stapple food in this area is Matooke (Plantain) and other foods commonly used are Cassava, and Sweet potatoes. The fact being that these are the commonest types of foods in the community, the project has gone ahead and encouraged them to use these Startch Based foods in treating diarrhoeas.

We have asked them to cut the Matooke, Cassava, or Potatoes in small pieces to fill half of the mug, then pour it in a source-pan, fill the sauce pan with one litre of water, mark the line, add ½ litre of water. Put on fire and boil until when the water dries to the marked line, add one leveled tea spoon of salt, mix well and leave it to cool then give the child as much as he can take.

Mr. Kuuku Wilson is the Chairman RC I Kyetume in the Sub-Parish of Vumba B. Kalagala Sub-county which is one of our Project Area. Wilson is a father to a young daughter who was admitted to Mulago, a National refferal Hospital for several weeks due to

.../2

diarrhoea. In Mulago the child was treated with all the antibiotics and the anti-parasitics available but as weeks past the child became weaker and weaker until when every one lost hope. Wilson was advised to take his daughter back home, since it would be cheaper for him to transport the family members before the child is dead. Among the community members who came to see the dying child, was Nakayenga, one of our Village Health Promoters. When she learnt that the killing disease was diarrhoea, she also wanted to give a try. She asked the parents to stop giving any other food or drink, but mashed Sweet bananas and Cereal Based Therapy from Maize porridge. Within a week, the child had come back to life.

Schedule 3 IMMUNIZATION

FOCUS AND ACTIVITIES

3 - 1 For the Immunization component of this project, please indicate if the project sponsored, promoted or participated in each activity during fiscal year 1993.

	Project activity during FY93? Yes	No
a. EPI promotion and services		
1. Activities directed to promote use of services	(Y)	N
2. Delivery of vaccination services through:		
- Mass campaigns	(Y)	N
- Fixed centers	(Y)	N
- Mobile vaccination teams	(Y)	N
- Outreach and follow-up services	(Y)	N
3. Vaccination of women with tetanus toxoid	(Y)	N
4. Vaccination against measles	(Y)	N
b. Training		
1. Training of health care professionals	(Y)	N
2. Training of outreach workers (TBAs, traditional healers, community health workers)	(Y)	N
c. Other activities		
1. Improved surveillance for vaccine preventable diseases	(Y)	N
2. Equipment and training for improved cold chain	(Y)	N
3. Other (specify) _____	Y	N

ADDITIONAL BACKGROUND INFORMATION

3 - 2 Please provide any other background information which would enable us to better understand the unique nature of the project's immunization component, including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. **Due to the newly announced measles initiative, we are particularly interested in hearing about any measles activity undertaken through this project.** (Attach additional sheets if necessary).

CHILD SURVIVAL INDICATORS

3 - 3 What is the **vaccination coverage rate** (see instruction guide for information on definitions) in the project area?

	BCG	DPT3	Polio3	Measles	Tetanus for Women
Percent vaccinated (children by 12 months, or women)	62	71	63	45	5
Date (month/year) data was collected	'89	'89	'89	'89	'89
Source of information (CIRCLE ONE)	*(DC) BG DK	*(DC) BG DK	*(DC) BG DK	*(DC) BG DK	*(DC) BG DK

* Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

d. If a data collection system was used, please describe it. Please give the name of the **agency** responsible for the system (MOH, WHO, UNICEF), its scope (national or project **area** specific), its **permanence** (special study or ongoing monitoring system), the **methodology** used (sample survey, clinic-based statistics, village-based statistic), and the **computational procedure** (weighting in a sample, weighting of data from clinics or villages, etc.).

MoH, Nsanje District 1989 annual report

Schedule 4 NUTRITION

FOCUS AND ACTIVITIES

4 - 1 For the Nutrition component of this project, please indicate if the project sponsored, promoted or participated in each activity during **fiscal year 1993.**

	Project activity during FY93? Yes	No
a. Breastfeeding		
1. Exclusive breastfeeding for first 4 - 6 months	(Y)	N
2. Initiation of breastfeeding within 1 hour after birth	(Y)	N
3. Increased duration of breastfeeding	(Y)	N
4. Continued breastfeeding during diarrhea	(Y)	N
5. Development of support groups or mechanisms for home visitation to counsel and assist mothers	(Y)	N
6. Revised policy for hospitals and maternity centers	Y	(N)
7. Policy dialogue in support of a favorable environment for breastfeeding	Y	(N)
b. Weaning and child feeding		
1. Community education for proper child feeding practices	(Y)	N
2. Emphasis on correct feeding during and after diarrhea and other infections	(Y)	N
3. Development and promotion of locally acceptable weaning foods	(Y)	N
c. Growth monitoring		
1. Use of growth monitoring as a tool for counseling mothers	(Y)	N
2. Use of growth monitoring as a means of nutritional status surveillance	(Y)	N
3. Strengthening of health worker skills in growth monitoring and counseling	(Y)	N
d. Vitamin A and other micronutrient deficiencies		
1. Assessment of levels of vitamin A deficiency	(Y)	N
2. Case detection and treatment of vitamin A deficiency	(Y)	N
3. Vitamin A supplements for children and/or post partum women	(Y)	N
4. Inclusion of vitamin A in treatment of measles	(Y)	N
5. Communication activities to promote increased dietary intakes	(Y)	N
6. Food fortification	(Y)	N
7. Home and community gardens	(Y)	N
8. Iron and folate supplements for women of reproductive age	Y	(N)
e. Training		
1. Training of health care professionals	(Y)	N
2. Training of outreach workers (TBAs, traditional healers, community health workers)	(Y)	N
f. Other_____	Y	N

SUPPLEMENTAL FEEDING TARGET GROUPS

4 - 2 If the project sponsored **supplementary feeding** during FY93, which groups were targeted? (CIRCLE ALL THAT APPLY)

1 - All ages
(2) Children under 12 months
(3) Children 12 - 23 months
(4) Children 24 - 35 months
5 - Children 36 - 60 months
(6) - Pregnant or lactating women
7 - Other women
8 - Other_____
9 - None
10 - Don't know

ADDITIONAL BACKGROUND INFORMATION

4 - 3 Please provide any other background information which would enable us to better understand the unique nature of the project's nutrition component including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary).

In collaboration with the IEF, the CS project became involved in vitamin A activities; education on vitamin A-rich foods and capsule distribution. Training of HSAs and volunteers began in early 1992. There were three capsule distributions to children between 3 months and 6 years of age and breastfeeding mothers of children under 3 months; June and December 1992 and June 1993. Approximately 8,500 capsules were distributed in the first distribution, 13,800 in the second and 15,700 in the third. The second distribution reached approximately 87% of the target population and the third, which included a larger area, reached approximately 79% of the target popula tior

CHILD SURVIVAL INDICATORS

4 - 4 a. What is the rate of malnutrition in the target group served by the project?

Definition: Rate of malnutrition is "the proportion of children whose weight-for-age is below two standard deviations of the norm established by the National Center for Health Statistics (the norm endorsed by the World Health Organization)."

	Group 1	Group 2	Group 3	Group 4
Target group →	Children 0-11 months	Children 12-23 months	Other 6-59 Specify months	Other Specify_____
Estimate rate of malnutrition →			3.6 %	
Date (month/year) of estimate →			10/92	
Source of information (CIRCLE ONE)	*DC BG DK	*DC BG DK	(*DC) BG DK	*DC BG DK

*Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

b. If a data collection system was used, please describe it. Please give the name of the agency responsible for the system (MOH, WHO, UNICEF), its scope (national or project area specific), its permanence (special study or ongoing monitoring system), the methodology used (sample survey, clinic-based statistics, village-based statistic), and the computational procedure (weighting in a sample, weighting of data from clinics or villages, etc.).

MSF/Holland, Nsanje District, ongoing monitoring during drought, sample survey

Schedule 5 HIGH RISK BIRTHS

FOCUS AND ACTIVITIES

5 - 1 For the High Risk Birth component of this project, please indicate if the project sponsored, promoted or participated in each activity during **fiscal year 1993.**

	Project activity during FY93? Yes	No
a. Community education to:		
1. Raise awareness of the importance of preventing high risk births	(Y)	N
2. Promote modern contraceptive methods for child spacing	(Y)	N
3. Promote breastfeeding as a method for child spacing	(Y)	N
4. Promote other natural family planning methods	(Y)	N
b. Strengthening of service delivery by:		
1. Developing a system to identify and refer high risk women for family planning services	(Y)	N
2. Training medical staff in clinical and counseling skills for child spacing methods	(Y)	N
c. Activities specifically directed at one or more of the following high risk groups:		
1. Women under age 18	(Y)	N
2. Women age 35 or older	(Y)	N
3. Women who have given birth within the previous 24 months	(Y)	N
4. Women with 4 or more children	(Y)	N
d. Training		
1. Training of health care professionals	(Y)	N
2. Training of outreach workers (TBAs, traditional healers, community health workers)	(Y)	N
e. Other _____ (please specify)	Y	N

ADDITIONAL BACKGROUND INFORMATION

5 - 2 Please provide any other background information which would enable us to better understand the unique nature of the project's high risk birth component including any activities not identified above, specific lessons learned, special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary).

CONTRACEPTIVE PREVALENCE RATE

5 - 3 What is the Contraceptive Prevalence Rate in the project area?

a. Contraceptive prevalence rate in area	7%
b. Date(mo/yr) data was collected	6/93
c. Source of the data used to make the estimate	(DC) BG DK

The definition of Contraceptive Prevalence Rate is "the proportion of women aged 15 - 44 years, or in some countries, 15 - 49 years, in union or married, currently using a modern method of contraception."

d. If a data collection system was used, please describe it. Please give the name of the **agency** responsible for the system (MOH, WHO, UNICEF), its scope (national or project **area** specific), its **permanence** (special study or ongoing monitoring system), the **methodology** used (sample survey, clinic-based statistics, village-based statistic), and the **computational procedure** (weighting in a sample, weighting of data from clinics or villages, etc.).

* Source Codes: DC: Data Collection System; BG: Best Guess; DK: Don't Know

ADRA CS 6, Nsanje district, final cluster survey

Schedule 6 HIV/AIDS ACTIVITIES

6 - 1 Does this project provide funding or otherwise support activities in HIV/AIDS prevention? ___ YES ✓ NO

If your answer is YES, please use the table below to define the scope of the HIV/AIDS activities supported under this project. Provide your data in columns B through G on the basis of the Activity Categories identified in Column A.

Column B Attribute to each specific Activity Category the corresponding percent from the total FY93 obligations to HIV/AIDs programs as listed in Question 9j of the main schedule. Column B should add to 100%.

Column C Estimate the percent of resources supporting research for each activity reported in Column A.

Column D From page 1, please list the organizations which were involved in HIV/AIDS activities supported under this project. Abbreviate if necessary.

Column E Use the numbers corresponding to Target Population descriptions as appropriate for each activity.

Column F Indicate by Y or N (Yes or No) whether activities listed in Column A are community-based with target community involvement in the design, implementation, and/or evaluation of the activities.

Column G Please cite the number of individuals reached by prevention efforts in each activity area. Use your best guess if no data has been collected for this variable.

A Activity Category	B % of AIDS Attribution	C % Research	D Organizations Supported	E Target Population	F Community-based	G Nos. Reached FY93
BER						
CSP						
CPD						
PNR						
STD						
PDM						
OA1						
	100%					

ACTIVITY CATEGORY CODES:

BER - Behavioral Research
CSP - Condom Supply
CPD - Condom Protection and Distribution
PNR - Partner Number Reduction
STD - STD Management and Control
PDM - Policy Dialogue/Modeling
OA1 - Other (please specify)_____

TARGET POPULATION CODES:

1 - General Public
2 - Community Leaders
3 - Children (0-8 years)
4 - Youth (9-14 years)
5 - Female Sex Workers
6 - Male Sex Workers
7 - Other Women at Risk
8 - Other Men at Risk
9 - IV Drug Users
10 - Health Service Providers
11 - STD Patients
12 - Other (please specify)_____

6 - 2 The AIDS Division of R&D/Health needs descriptive information on all Mission sponsored HIV/AIDS programs for the Agency's Report to Congress. We would encourage you to attach to this questionnaire a brief but comprehensive description on the HIV/AIDS programs your project sponsors. Providing this information now would eliminate the need for further requests for such summaries.

Schedule 7 OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES

This schedule is designed to record information about health and child survival interventions other than those identified in schedules 2 through 6

IDENTIFICATION OF OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES

7 - 1 What type(s) of "other" health and child survival interventions received funding or other support through this project? (CIRCLE ALL THAT APPLY)

1 - Acute Respiratory Infection (answer 7 - 3)
2 - Maternal Health (answer 7 - 4)
3 - Health Care Financing (answer 7 - 5)
(4) Malaria (answer 7 - 6)
(5) Water and Sanitation
(6) Elderly/Adult Health
7 - Prosthetics
8 - Tuberculosis
9 - Other (please specify)_____

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7 - 2 Please provide any other background information which would enable us to better understand the unique nature of the project's other health and child survival activities, including those not identified above, any specific lessons learned, any special steps taken to promote long-term sustainability, etc. (Attach additional sheets if necessary). Unanticipated Constraints

The most serious draught in sixty years affected the project regfion with severe food shortages from mid 1992 through the first trimester of 1993. ADRA participated on the Draught Relief Coordinating Committee. It was decided that ADRA would continue regular project activities while MSF carried out nutrition surveys and the Red Cross was responsible for food distribution. Although the program did continue it was hampered in many ways; Volunteers were not able to devote as much time to project activities because they had to find food for their families; some of the villagers moved temporarily to areas close to the river where they could cultivate which appears to have resulted in (over

FOCUS AND ACTIVITIES

For the interventions specified, please indicate which of the following activities are major elements of the **life-of-project** implementation strategy (in terms of project funds and human resources committed for this intervention); and 2) whether or not the project sponsored, promoted or participated in each activity during **fiscal year 1993.**

PLEASE ANSWER 7 - 3 ONLY IF YOU CIRCLED "1 - Acute Respiratory Infection" IN RESPONSE TO 7 - 1.

7 - 3 Acute Respiratory Infection Strategies	Project activity during FY93? Yes	No
a. Community-level education to:		
1. Raise awareness of the dangers of acute respiratory infection	Y	N
2. Enable mothers to recognize when prompt medical treatment is necessary	Y	N
b. Case management of respiratory infection:		
1. Training of clinical staff in case management and treatment	Y	N
2. Training of community workers in case management and referral	Y	N
3. Provision of equipment and timers for diagnosis	Y	N
4. Provision of appropriate drugs for pneumonia treatment _____ (specify drugs)	Y	N
5. Education of health staff and pharmacists to encourage rational use of antibiotics	Y	N
c. Other _____ (please specify)	Y	N

7-2 (continued)

continued dislocation of some village populations; staff members spent more time collecting water for their own needs; the garden component lapsed in many places; diarrhea, including bloody diarrhea and cholera were prevalent due to the poor quality of water; many people did not have enough to eat; MOH resources were diverted to cholera camps resulting in a breakdown of the MOH distribution system and shortages of ORS and other medications throughout the region.

OTHER HEALTH AND CHILD SURVIVAL ACTIVITIES (continued)

ANSWER ONLY IF YOU CIRCLED "2 - Maternal Health" IN RESPONSE TO 7 - 1.

7 - 4 Maternal Health Strategies	Project activity during FY93? Yes	No
1. Communication activities to increase women's healthy practices during pregnancy, and use of prenatal care and maternity services	Y	N
2. Training and equipment for traditional birth attendants (TBAs), midwives, and other health workers:		
- training in screening and referral of high-risk pregnancies	Y	N
- training in life-saving delivery skills	Y	N
- provision of safe delivery kits	Y	N
3. Strengthening referral systems between TBAs, health centers, and hospitals	Y	N
4. Integration of maternity care with family planning	Y	N
5. Treatment of infections, especially sexually-transmitted diseases	Y	N

ANSWER ONLY IF YOU CIRCLED "3 - Health Care Financing" IN RESPONSE TO 7 - 1.

7 - 5 Health Care Financing Strategies	Project activity during FY93? Yes	No
1. Fees for health services	Y	N
2. Income generation to support project activities _____ (please specify)	Y	N
3. Other _____ (please specify)	Y	N

ANSWER ONLY IF YOU CIRCLED "4 - Malaria" IN RESPONSE TO 7 - 1.

7 - 6 Malaria Strategies	Project activity during FY93? Yes	No
a. Prevention		
1. Public education to:		
- increase awareness of malaria and methods of prevention	(Y)	N
- enable mothers to recognize when and where to seek treatment	(Y)	N
2. Prevention of disease transmission through:		
- personal protection methods (impregnated bednets, etc.)	(Y)	N
- vector control (against adult mosquitos, against larvae, etc.)	Y	(N)
- environmental management	Y	(N)
b. Case management of malaria		
1. Standardization of protocols for case management	(Y)	N
2. Training of community workers in case management and referral	(Y)	N
3. Training of clinical staff in case management and treatment	(Y)	N
4. Provision of antimalarial drugs	(Y)	N
c. Other _____ (please specify)	Y	(N)